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MONTREAL

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MENTAL HEALTH FOR NURSES
W. H. Cruickshanks, M.D.

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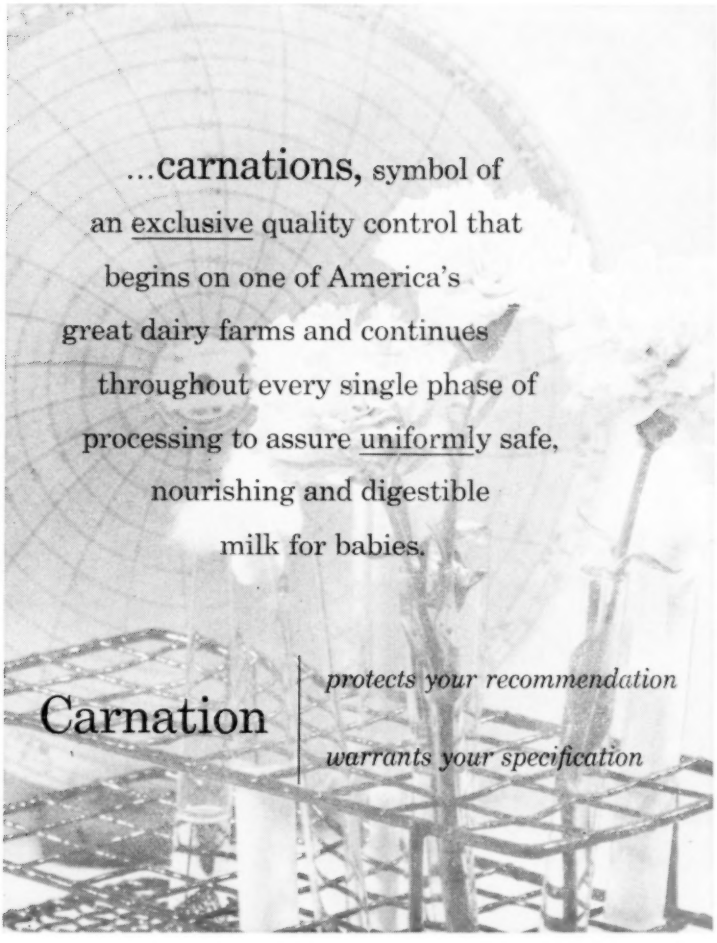

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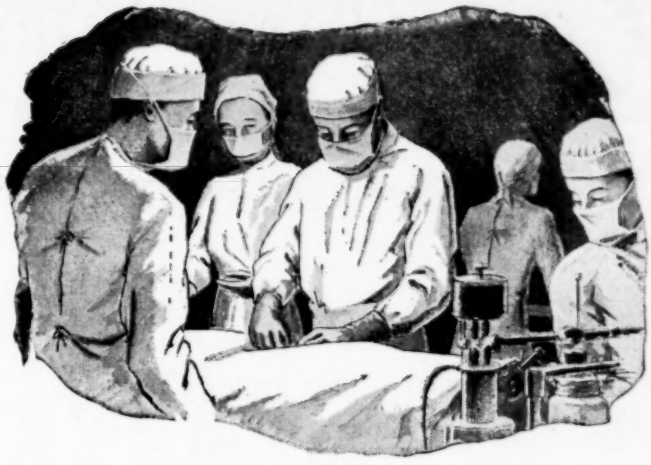

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VOLUME 52 **NUMBER 2**

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Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
Student nurses — one year, $2.00; three years, $5.00. U.S.A. & foreign: one year, $3.50; two years, $6.00.
In combination with the *American Journal of Nursing* or *Nursing Outlook:* one year, $7.00.
Single copies, 35 cents.
Make cheques and money orders payable to *The Canadian Nurse.*
Detailed *Official Directory* appears in **June & December.**
Please give one month's notice of *Change of Address.*
Authorized as Second-Class Mail, Post Office Department, Ottawa.
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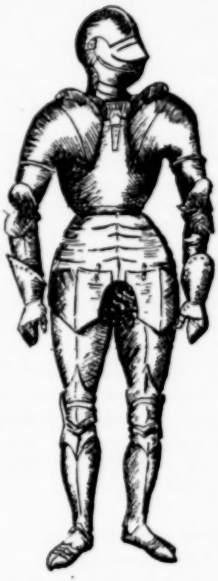

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Between Ourselves

Anticipating the theme for the 1956 convention, Chairman of the Nursing Service Committee **Alice Girard**, as our guest editor, poses some very penetrating questions. Miss Girard is keenly alert to the problems she presents for she is director of nursing at Hôpital St. Luc in Montreal. She realizes, as do directors of nursing everywhere, that there just are not enough pairs of hands available to meet the demands for nursing service in hospitals and public health organizations alike. Seeking the answers to these questions is the responsibility of every member of the profession. The Committee on Nursing Service can and does give superb leadership in the quest but 15 or 20 committee members or even 1500 or 2000 interested nurses are not enough — it is up to all of us to give our loyal assistance.

* * *

One answer is being furnished by the women who are being trained in schools similar to the one described by **Emily Groenewald.** Sponsored by the Department of Veterans Affairs there are schools for nursing assistants in three centres — Toronto, Montreal and Halifax. Like the schools organized under the provincial health departments, these schools follow the pattern defined by the Canadian Nurses' Association. Thus opportunity is provided for persons who are not able to enter our schools of nursing to become qualified so that they too may swell the numbers of those who can give reality to our convention theme "Nursing Serves the Nation."

* * *

Last September, **Dr. W. H. Cruickshank** gave a very thoughtful address at the convention of the Canadian Public Health Association. He took as his topic the problems of Mental Hygiene in Industry. The paper was published, as given, in the *Canadian Journal of Public Health* in December, 1955. Permission was given for us to reprint it but as we read it through, the thought recurred, again and again, of how applicable all of the points were to improving the mental health of nurses. If only we could slant the material directly to our profession! Happily, as soon as Dr. Cruickshank was approached regarding this possibility he was completely willing to cooperate with us in this transposition of emphasis. We hope that, as and when your tensions may mount, you will turn again to Dr. Cruickshank's outline of desirable mental health activities to find guidance in relieving tension-producing situations.

* * *

How can usually active children be kept entertained and occupied when accident or illness makes it necessary for them to stay in bed for a while? Children's hospitals have departments of play therapy organized to meet this need. Even in small pediatric units attention is given to keeping the not-too-sick child busy. What happens when he goes home? How about the child whose disability has not required hospitalization?

Louise Price Bell, out of her experience as a nurse and as a mother, gives some very practical answers to these questions in her "Counterpane Land." She points out how inexpensively the necessary materials can be procured. Every nurse, but particularly those who see the children in their homes, will find this article a most helpful supply cupboard of ideas and suggestions.

* * *

How are your plans maturing for attendance at the CNA convention in Winnipeg next June? As noted in "Nursing Across the Nation," the number of pre-registrations is mounting steadily at National Office. How about *your* post-convention plans? That trip to Honolulu described by **Ethel Armstrong Collins** sounds pretty alluring, doesn't it? Just south of the Tropic of Cancer, the Hawaiian Islands are *never* too hot yet they are warm enough for sea and sun bathing at any time of the year.

If your heart was set on the Klondyke Gold Nugget tour, we are very sorry that you will have to be disappointed. Switch your plans and explore the eastern parts of Canada instead. Aren't you relieved to learn that others besides honeymooners do go to Niagara Falls? Be sure to visit the National Office when you are in Ottawa. The Journal office is very easy to find when you reach Montreal. On the south side of Sherbrooke Street, 1522 is just east of Guy Street. Come and see us!

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New Products

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NEMBU-SERPIN

Manufacturer—Abbott Laboratories, Ltd., Montreal.

Description—Each tablet contains: Nembutal (pentobarbital) calcium 30 mg.; reserpine 0.25 mg.

Indications—As a sedative and tranquilizer in mild anxiety states, tension, insomnia and in mild essential hypertension.

Administration—In mild anxiety states, etc., 1 tablet at bedtime with additional tablets during the day as indicated. Maximum daily dose 4 tablets. In mild hypertension, 1 or 2 tablets daily.

PLACIDYL

Manufacturer—Abbott Laboratories, Ltd., Montreal.

Description—Each red gelatin capsule contains: Placidyl (B-chlorovinyl ethyl ethynyl carbinol) 500 mg., a nonbarbiturate hypnotic with low toxicity which does not produce initial excitation or a "hangover" effect.

Indications—Simple insomnia resulting from tension, mild anxiety, mild excitement or agitation.

Administration—Adults, 500 mg. 15 to 30 minutes before retiring. Duration of effects is 4 to 5 hours. Only mild side effects have been reported — mild depression, symptoms of mild excitation and stomach upsets occur rarely.

STATIMO

Manufacturer—Charles E. Frosst & Co., Montreal.

Description—Carbazochrome salicylate complex, tablets of 2.5 mg., and ampoules of 5 mg.

Indications—Capillary hemorrhage.

Administration—Intramuscularly, 1 cc. every 2 to 4 hours until bleeding ceases; orally, after bleeding has been controlled, by injection or for initial and maintenance therapy, 1 tablet every 4 hours.

VALMID

Manufacturer—Eli Lilly and Company (Canada) Limited, Toronto 13, Ontario.

Description—A short-acting nonbarbiturate sedative having a rapid onset of effect.

Indications—For the management of simple insomnia caused by mental unrest, excitement, fear, worry, apprehension or extreme fatigue.

Administration—Adults: 1 or 2 tablets 15 to 20 minutes before retiring. May be administered to patients who are hypersensitive to barbiturates.

MIGRAINE TABLETS

Manufacturer—Organon Inc., Canadian Branch, Montreal.

Description—Contain: Ergotamine tartrate 1.0 mg., caffeine 100.0 mg., belladonna alkaloids levarotatory 0.1 mg. and acetophenetidin 120.0 mg.

Indications—For the treatment of migraine headaches.

Administration—Early recognition of symptoms and proper dosage are of prime importance in vascular headache therapy. A dose of 2 tablets should be taken immediately upon noticing symptoms of migraine (prodromal stage), followed by 1 tablet every 20-30 minutes until the attack aborts. No more than 6 tablets should be taken per migraine attack.

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Manufacturer—Astra Pharmaceuticals (Canada) Ltd., Toronto, Ont.

Description—Contains 2% Xylocaine hydrochloride in an aqueous solution adjusted to suitable consistency with carboxymethylcellulose. Cherry flavored for palatability.

Indications—Provides prompt and prolonged topical anesthesia of the proximal parts of the digestive tract. Controls hiccup and reflex vomiting, including severe vomiting of pregnancy, and relieves the discomfort of laryngoscopy, esophagoscopy and gastroscopy. Useful also in the symptomatic management of acute cardiospasm and pyloric spasm, stomatitis, pharyngitis and esophagitis.

Administration—Administered orally. Dosage as follows: Average dose: 1 tablespoonful administered orally.

Pyloric spasm: Adults, 1 tablespoonful as necessary, followed by half a glass of water, maximum 3 times daily; infants, 1 teaspoonful.

Gastroscopy and gastric intubation: 1 tablespoonful.

Esophagoscopy, esophagitis, stomatitis: 2 teaspoonfuls to 1 tablespoonful carefully distributed in the mouth and slowly swallowed, not followed by water.

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Description—Each yellow scored lemon-flavour tablet contains: Ascorbic acid 500 mg., menadione 10 mg.

Indications—For protection against hemorrhage in tonsillectomy and other surgery. Also in certain hemorrhagic states coexisting with ulcerative colitis, sprue and celiac disease. During last month of pregnancy.

Administration—Adults, one every 24 hours; children, one-half to one every 24 hours. To be used only as prescribed by physician.

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Manufacturer—Bristol Laboratories of Canada, Limited, Montreal, P.Q.

Description—Each sugar coated tablet contains: Reserpine 0.05 mg.; phenobarbital 0.15 mg. (¼ gr.); and centrine 0.25 mg. Reserpine promotes tranquillity and a sense of well-being. Phenobarbital induces sedation. Centrine inhibits gastrointestinal spasms.

Indications—Spastic conditions of the gastrointestinal tract, especially those associated with tension, anxiety and stress. Also as an adjunct in the management of spastic colitis, biliary colic, pylorospasm, peptic ulcers and morning sickness.

Administration—For oral use only. Dosage will depend on the individual patient's response as well as on the duration and severity of the condition. Adults: Usual dose is 1 or 2 tablets, 3 or 4 times daily. Children: Dosage according to age and weight.

SEDWELL

Manufacturer—Paul Maney Laboratories of Canada Ltd., Hamilton, Ont.

Description—Each teaspoonful contains: Fl. ext. belladonna 1/80 min., fl. ext. hyoscyamus 1/80 min., potassium bromide 5 gr., sodium bromide 5 gr., ammonium bromide 5 gr., zinc bromide 1/10 gr., ext. of hops 1/10 gr., fl. ext. cascara sagrada 1/10 min.

Indications—As an anticonvulsant in epilepsy and petit mal. Also as a sedative in insomnia, hyperthyroidism, alcoholic excitement, hot flashes and headaches of the menopause, etc.

Administration—Adults, as a single dose sedative, one to two teaspoonfuls. For continued use, one teaspoonful 3 times daily for 5 days, or 2 teaspoonfuls 3 times daily for shorter periods.

TRAWILL CAPSULE

Manufacturer—Charles R. Will & Co. Ltd., London, Ont.

Description—Each capsule contains: Dry extract rauwolfia 4% total alkaloids 10 mg. (equivalent to 0.4 mg. total alkaloids), butabarbital 16 mg.

Indications—Anxiety neuroses, tension states, certain neuropsychiatric conditions and essential hypertension.

Administration—One capsule 3 or 4 times daily as prescribed.

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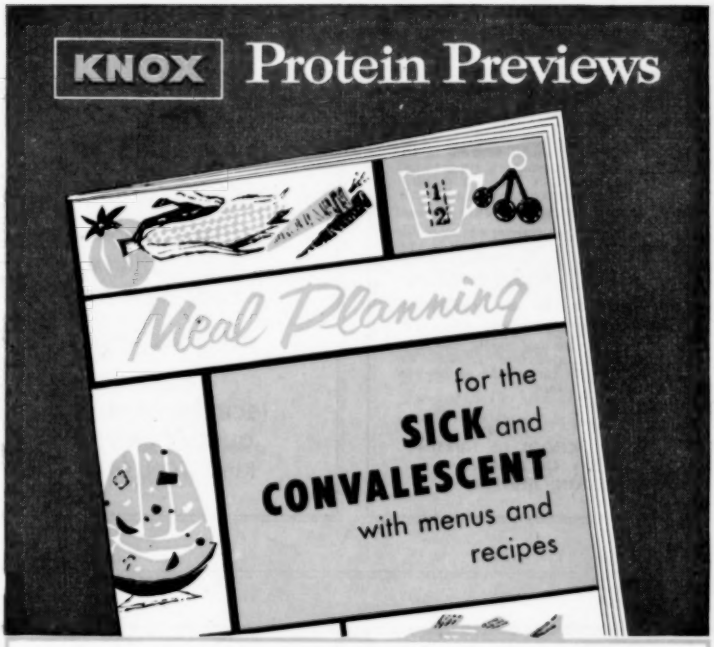

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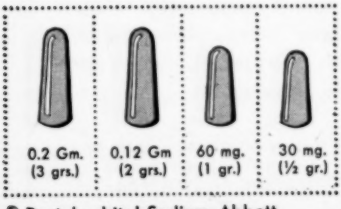

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THE CANADIAN NURSE

L'Infirmière Canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 52 NUMBER 2

MONTREAL, FEBRUARY, 1956

Too Few for Too Many

IN ONE OF THE RARE MOMENTS left for reading in the busy life of a director of nurses, I opened a recently published book and glanced at the first chapter which was entitled "Too Few for Too Many." This punch line, as a radio script writer would surely call it, caused me to pause and reflect at length on the subject, for it dealt with the vexatious dilemma of too few workers to care for too many patients. This, I thought, was surely one of the first problems we must solve in order to fulfill adequately our motto for the next biennium which is "Nursing Service for the Nation." To what extent can we Canadian nurses fulfill our obligation of nursing service to the people of this country? Are we facing this problem from the angle of actual service given or are we speculating in figures, complacently thinking in terms of ratios that make us feel good, for we *do* have one nurse per 300 of population? Do we seriously consider that our pledge of rendering service means that it must be available to the rich and the poor; to the city dweller, the mine worker and the farmer; in hospitals and at home; in industries and in schools? Are we fully aware that service means: performance of labor for the benefit of others or a means of supplying some general demand?

If we accept the fact that we have too few workers to care for too many patients what are we doing about it? We are asking for surveys and research studies but can we all truly say that

ALICE GIRARD

Miss Girard, who is second vice-president of the CNA, is director of nursing at Hôpital St-Luc, Montreal.

when these are done we make great efforts to study, discuss and apply the recommendations? To what extent have we used the findings of the Head Nurse study? This could help us to a more effective utilization of the "Too Few".

Have we exploited to the fullest the possibilities at hand in the judicious utilization of our auxiliary personnel or are we too busy analyzing our fear of this group? If we cannot take upon ourselves the whole task of caring for the nation — and it seems evident that we cannot — then why not face the problem squarely and accept the fact that the auxiliary group is here to stay because we need it? Once reconciled to this idea the sooner we sincerely work on the integration of this group into the nursing family through adequate training, proper orientation and honest recognition of its merit, the more effective we will be.

Teamwork, when well organized, has helped us to redistribute the nurse's load of care and responsibilities and thus enhance her efficiency. Have we taken full advantage of this precious tool? There are a variety of ways by which we can improve the service we give with the resources on hand, but in order to do this each one of us must, in a way, be her own research worker. It is not given to everyone to be a creative thinker but everyone can scrutinize, analyze and evaluate her work with the object of changing or discarding the things that do not seem to fit in the complex pattern of our task as we see it now rather than continuing to think of it as it was twenty years ago.

Since we defined service as the performance of labor for the benefit of others or as a means of supplying some general demand, it seems unwise to think that this can be done without the help of those who are to benefit from this service. The time has passed when it was improper to tell of our good deeds and to share our problems with the public. We have learned through business organizations that it pays to inform the consumer of the quality of a product and its proper utilization. Why shouldn't the public be aware of the problems the nursing profession faces in trying to staff more and more hospitals and public health nursing organizations since these are the result of public demand? It will eventually be the public who, as the consumer, will interpret to our various governments our legitimate demands as it makes known its needs and claims its rights. Yes, we do need to build good public relations if we want to attain our aims. Nursing service for all the nation is the public's right and it is the duty of our profession to be prepared with the help of the proper authorities to give this service or to admit failure. Failure is not in our tradition.

When we convene in Winnipeg next June let us all reexamine our aims and methods in the light of what we wish to accomplish. If our goal seems ambitious let us remember that a poet once wrote: "A man's reach must be beyond his goal or what is heaven for?"

ALICE GIRARD
Chairman
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Have you ever noticed?

When the other fellow acts that way, he is "ugly;" when you do it, it is just "firmness."

When the other fellow doesn't like your friends, he's "prejudiced;" when you don't like his you are simply showing that you are "a good judge of human nature."

When the other fellow spends a lot, he is a "spendthrift;" when you do, you are "discriminating."

When the other fellow takes time to do things, he is "dead slow;" when you do it, you are "deliberate."

When the other fellow holds on to his money too tightly, he is "tight;" when you do, you are "prudent."

When the other fellow runs great risks in business, he's "foolhardy;" when you do, you are a "great financier."

When the other fellow says what he thinks, he's "spiteful;" when you do, you are "frank."

When the other fellow won't get caught in a new scheme, he's "backwoodsy;" when you won't you are "conservative."

When the other fellow goes in for music, pictures and literature, he's "effeminate;" when you do, you are "artistic."

— CONTINENT

Mental Health for Nurses

W. H. CRUICKSHANK, M.D., D. PSYCH., D.P.H.

WITH EACH ADVANCING YEAR it is realized that more and more symptom complexes, formerly considered to be organic in nature, are explainable on the basis of reaction to emotional tension, fear, frustration and insecurity. These fears and frustrations, in some instances, lead to actual breakdown but much more commonly result in translation to physical symptoms that may be referable to almost any of the body systems and give rise to headaches, dizziness, stomach trouble, rapid heart and increased blood pressure, to extreme fatigue or even paralysis.

Emotional responses were designed originally to prepare the body for fight or flight in the face of danger. In a complicated society such as we now have, where one can no longer respond to emotion by physical fight or flight, these responses are expressed in different ways. They can be very disturbing and the basis of a great deal of ill-health. Thus emotional ills appear to be disorders of an increasing civilization.

The problem of emotional or mental ill-health within the population is no small one. The actual incidence of disorders of emotion and morale is not accurately known. It has been estimated, however, that such disorders account for as much as one-third of the total disability rate. About 60 per cent of the patients who attend outpatient departments of general hospitals do not suffer from organic disease.

In addition to its importance as a primary cause of lost time, the effect of emotion and attitude on duration of organic illness and on rehabilitation is not inconsiderable. If one adds to this the effect of non-disabling, unhealthy emotional reactions on efficiency, morale and cooperation the importance of the subject in relation to overall nursing efficiency is almost overwhelming.

What is our definition of mental health? Mental health implies an ability to live in harmony with one's environment, to survive, to compete and to discharge one's responsibility in relation to personal capacities, to get along with people, to acquire skills that are consistent with ability, to obtain satisfactions, to accept and to live with or overcome personal limitations and to accept the consequences of one's behavior. Environment must be included in any definition of mental health. There are always the two variables, the individual and the environment. It may be important to point out that regardless of the qualities of the individual there are some environments in which a high level of mental health cannot be achieved.

One of my teachers would greatly simplify the definition of mental health by equating it to happiness and, in turn, to security. He would define mental ill-health as unhappiness and a feeling of insecurity. Under such a definition it can be readily seen that mental health is a relative state since no human is completely happy or completely secure or completely self-sufficient. This is not to be interpreted that few are mentally healthy. Some insecurity, and some unhappiness must be regarded as a normal rather than abnormal state.

What are the causes of mental or emotional ill-health? Those interested in the subject quickly come to realize that there is never, in a given case, one single causative factor, as was once thought. The cause never appears as a bolt from the blue, nor as a mysterious entity destined to implant itself at a particular period on unprepared soil. The cause is a process — something that moves and shapes itself in the passage of time. It doesn't just happen. The effects of heredity, child guidance and habit training, all the environmental influences and experiences in childhood and youth, of phys-

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ical health, culture, etc., all have a bearing on ultimate emotional stability. Surely this concept of etiology provides increasing incentive in our urgent desire to promote mental health and to prevent mental ill-health. That we have a long way to go in mental hygiene is suggested by the large number of people who achieve chronological maturity while still retaining emotional immaturity to a degree that interferes with their ability to live in harmony in the situation in which they find themselves.

On the bright side, however, we have accumulating evidence to suggest that *behavior can be predicted and that the process of personality maturation can be influenced.* There is now good reason to believe that a child who is loved will almost invariably be capable of loving others. There is now ample evidence to show that a child who has not had love will be hostile and will lack trust in people; that a child who has been over-protected, never allowed the opportunity to develop independence appropriate to his age, will be neurotic and dependent; that a child who grows up in association with people who have respect for the rights of others and the laws of society, will also have respect and consideration for the rights of his fellow-men; that a child who has been rejected will usually be resentful, often delinquent and always insecure. Much progress has been made in the area of child guidance. Our mental hygiene activities, however, must not stop with parent education and teacher training but must be extended throughout adult life. The maturation of personality does not stop with the cessation of physical growth. Under favorable conditions it may extend throughout the major period of adult life.

Do these fundamental mental health observations just mentioned have any bearing on the mental health of nurses? Are nurses susceptible to the effects of love, recognition, rejection, over- and under-protection, satisfaction, rewards and discipline? We know that adults on the surface are more sophisticated. We know that they have been conditioned by all previous life experience. In spite of this, my observations would lead me to believe that the fundamental responses to love, protection, rejection, recognition and other forms of stimuli remain relatively unchanged in the nursing profession. That nurses like to be recognized, like to have at least a measure of control over their own affairs, like to have the opportunity to develop skills appropriate to their individual capacity and, through the acquisition of skills, to enjoy a measure of independent security, unfortunately, is a relatively recent discovery.

Observation would tend to suggest that the mental health needs of students in a school of nursing are not fundamentally different from what they are in the home. Just as parents now recognize the importance of participation, responsibility, example and discipline in child development, so schools of nursing should look at the advantages of providing those conditions of work that foster the development of nurses who are mature and are capable of independent thought and action.

Nurses like to be recognized. Nurses like a democratic opportunity to advance and to acquire independent security consistent with their efforts. That work should be a method rather than just a means of living is a new concept but fundamental to mental health.

The mental health needs of nurses are intimately related to the work situation. The acute emotional reaction which gives us windy indigestion, clammy hands, rapid heart and difficult breathing, for example, when one has to give a speech, does little or no harm to health. Chronic emotional response to a grievance, to frustration, to continued fear or to lack of job satisfaction, undermines health, produces inefficiency and brings about a desire for a change in the order of things. Chronic anxiety undermines health. The importance to the career worker of a satisfactory job situation is such that if she achieves satisfaction in her job her private conflicts become of secondary importance. There is a good deal of evidence to suggest that the opportunity to acquire skills through vocation and avocation is probably the most important single factor in mental health in our com-

petitive society. The more skills we have the more independently secure we are. It is more difficult to take away our skills than to take away any of our other possessions. Our skills are our greatest source of recognition and our main hope of immortality. People can stand great adversity and still be happy if acquiring skills and progressing toward a goal.

Work and the work situation, therefore, are important to mental health. As would be expected, they are also important as causes of mental ill-health. Of all the mental health problems it is probably true that tensional states are by far the most common. Many tensional states arise in the work and work situation of the average nurse.

Tension

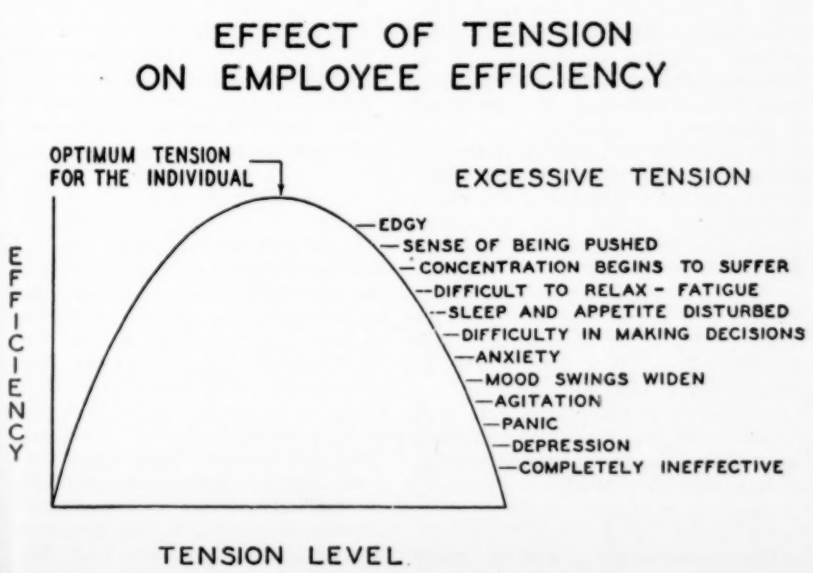
"Tension" is spoken of rather glibly and yet it is rather difficult to define. Dr. D. E. Cameron defines tension as a state of "preparedness for action." This is a very practical definition. The physiologists have for years used the word "tone" to describe the state of a muscle which enables it to act efficiently and immediately in response to the will. Preparedness for action is a desirable state and, as would be expected, is related to efficiency. A muscle that is without tone is clumsy and ineffective when called upon to undertake precise movement. Likewise the person who is not prepared for action is ineffective. We all recognize the nurse who has a healthy level of tension, who is prepared for action. She is referred to as a self-starter. The head nurse likes to have her on her ward.

Some people have a low tension level and require continual prodding. They are usually inefficient.

The accompanying figure shows graphically the relationship between the efficiency and tension level. As tension is raised efficiency increases. As tension is increased beyond the optimum efficiency goes down.

The responsibility of the supervisory staff in our hospitals is to maintain the tension of nurses at an efficient level. Sometimes they fail to realize, however, that when the tension level is raised too high, efficiency goes down. Excessive tension, when prolonged, not only reduces efficiency but undermines health.

The effective nurse is the one who can maintain her tension level at or near peak efficiency. She will occasionally get the wheels going too fast and then cut back a bit as she notices that



she becomes edgy or irritable and not quite so effective. To some, however, such symptoms are merely a signal calling for greater effort or increased activity. When this occurs, a vicious circle is established with productivity going down and tension going up. Under these conditions typical symptoms develop. Concentration begins to suffer. Relaxation is impossible. Fatigue develops. Adrenalin is pumped into the blood stream too fast. This is the fear reaction. Sleep and appetite are disturbed. The heart may start to pound. Decisions become increasingly difficult. With indecisiveness comes real anxiety followed by depression, a feeling of hopelessness. Agitation usually precedes panic. At this stage, such a person needs positive help. Relatively few people go through the entire cycle, but, many nurses do get over into dangerous tension levels with adverse effects both on their work and their health.

The ability to withstand tension varies markedly from person to person. It is important to realize that everyone is susceptible to unhealthy tension levels under certain conditions. Everyone has a breaking point. In some, however, the tension tolerance, for one reason or another, is very low. The mere effort of living, even in a protected environment, may produce disabling tension levels. At the other end of the scale some can apparently withstand almost endless tension-producing stimuli with surprisingly little in the way of impairment to efficiency.

What causes the wide variation in the susceptibility of people to tension? There may be heredity factors. These do not seem to be very important. Most of us would agree that environmental influences are more important in determining our personality development and our ability to withstand tension. The ability to withstand tension depends on all of our past experience including our habit training, our opportunities to accept and deal with responsibility, our intellectual capacity, our physical health and, undoubtedly, on our philosophy of life.

Susceptibility to Tension

There are certain groups of people who are characteristically more susceptible to tension than others:

1. *Physically handicapped* persons do not stand tension well. Nurses with hearing defects, fallen arches, arthritic involvements, etc., compete unfavorably, both socially and economically, and unless they possess unusual personality maturity tend to be tension prone.

2. *Advancing years* may be a factor. Our society tends to discard age and experience in favor of youth. Older nurses are at a disadvantage and they tend, for this reason, to be tension prone. There are many reasons for this. Often older people have not achieved the goals they have set for themselves. They have become less adaptable. Often they have devoted a major portion of their lives to one position and they may resent new authority. The pre-retirement group are particularly susceptible to tension and require careful and extremely considerate leadership.

3. People with certain *personality characteristics* are tension prone. Those who lack confidence, those who are hostile and do not trust people, those who find it difficult to work with people, those who are easily frustrated or are highly sensitive are prone to excessive tension.

4. The *type of motivation* in the individual has a bearing on susceptibility to tension. Those who are over-motivated are impatient and tension prone. Those who are poorly motivated are tension prone if prodded. Those with conflicting motives tend to be tension prone. Those who are over-motivated who also have limited capacity, are particularly susceptible to tension.

Tension Stimuli

So people vary in their ability to withstand tension. The process of living inevitably produces contact with tension-producing stimuli. These may be related to problems in the home, in the community or at work. Some of the factors that are tension-producing may be listed:

1. *Responsibility factor* — The amount and kind of responsibility have a bearing. Strangely enough, work with not enough responsibility will produce excessive levels of tension in aggressive people just as readily as work with

excessive responsibility. Any form of supervisory work, from the director of nursing down to the most junior assistant head nurse, carries a potentially high tension rating. It is important to realize that when responsibility is clearly defined it is much less tension-producing than indefinite or ill-defined responsibility. Responsibility accompanied by authority is less tension-producing than responsibility that is devoid of authority. These are important considerations in the placement of staff.

2. *Physical factors* — Where the physical demands of the work are beyond the physical capacity of the nurse, tension is prone to develop. This is readily observed in the older nurses who return to work, perhaps after years of separation from actual nursing care.

3. *Unpredictable flow of work* — Surges of responsibility and patient-load affect the level of tension. The adverse effect is exaggerated if there does not seem to be justifiable cause for the change of pace.

4. *Intellectual requirement* — Work requiring either more or less capacity than the individual nurse has tends to produce insecurity or boredom, with resultant unhealthy tension levels.

5. *Pressure* — The feeling of being pushed either by the volume of work to be done or by time in which to do it effectively is typically tension-producing.

6. *Repetitive tasks* — Doing the same routine duties over and over again usually demands only a limited range of the nurse's skills and thus may be tension-producing. This is a major problem in considering the mental health of nurses.

7. *Creative work* — There are fewer opportunities for creative or imaginative effort in nursing activities than in many other professions or occupations. In some persons, this lack of opportunity for recognition may produce tension.

Working Environment

The working environment has a bearing on the tension level. Some of the factors that are of importance in this connection may be listed:

1. *Supervision:* The administration's job is to keep the tension at an efficient level. If it is too low, work suffers. If it is too high both work and health suffer. The leadership ability of the supervisor is important in this regard. When staff nurses lack confidence in the supervisor or the head nurse the tension level of the entire group is affected. If the supervisor is a poor leader, if she discriminates, if she fails to recognize good work, the tension level is affected and poorer work results. *Good supervision will go a long way toward maintaining healthy levels of tension in any situation.*

2. *Rigid standards* tend to raise tension levels. This is particularly so if the need for such rigidity is neither understood nor considered necessary by the staff members.

3. *Non-Acceptance:* In group activities it is essential to be and feel a part of the group. A nurse who feels that she is not accepted by the head nurse, by the staff on the ward or even by the patients will be inefficient and tension prone. A supervisor who is not accepted by subordinates will develop unhealthy tension.

We have reviewed at some length factors that influence tension level, including variations in susceptibility to tension. We have discussed the adverse effect of tension on physical and mental health and on the level of work. What can be done about it? How can we develop working conditions that will avoid these undesirable results?

It is important again to state that an optimum level of tension is essential. In fact the whole administrative staff has an obligation to keep the tension of the nursing team at an effective level. This is not only healthy for the work to be done but there is some indication that it is also healthy for the nurses involved. However, the prevention of unhealthy or inefficient levels of tension is one of the big challenges in a mental hygiene program.

Mental Health Practices

This brings us to a discussion of desirable mental health activities:

1. *Hospital Policies:* The mental health program in any hospital starts with its broad policies of administration. Those policies that enhance the qualities of the individual nurses, both graduate and student, by contributing to their

satisfactions and their recognition, those that encourage their participation and foster their growth and development contribute to their mental health. Those policies that degrade the status of the individual produce anxiety, feelings of tension, insecurity, and inevitably result in mental ill-health.

2. *Leadership:* Just as the major share of responsibility in child guidance has fallen on the shoulders of parents and teachers, so the burden of mental health and morale in hospital work must fall on those who are in authority — the doctors, the administrative officers, the instructors, the supervisors and head nurses. All group effort depends on organization which demands leadership.

Leadership may be defined as the skill in developing cooperative effort. Good leadership is probably the most important single factor in any mental health program. It is a skill requiring great ability and wide experience. Leaders are not born. They acquire their skills by training and doing. The selection, continued training and development of leaders is an important challenge. The crucial inter-personal relationship on the ward takes place between the nurse and the first level of management. Unfortunately the first level of management, the head nurse, is usually the least experienced. She may or may not have special aptitudes of leadership. She often has not had extensive experience and certainly is not likely to have had much practice in leading people.

3. *Conditions of work:* Working conditions which provide, among other things, freedom from discrimination, a democratic opportunity to advance, work assignments that are meaningful and lead to the development of useful skills, a healthy degree of security, and rewards that are roughly commensurate with effort, are fundamental to morale and to mental health.

4. *Placement (vocational guidance):* Careful placement of nurses in positions from which they can gain satisfaction is a vital consideration in mental health. This is particularly true in the appointment of young graduates. When they are placed in positions that are beyond their ability, they become insecure and unhappy through lack of accomplishment. On the other hand, a nurse obtains little in the way of lasting satisfaction from work that requires only a limited portion of her ability. The challenge in placement, then, is to ascertain the interests, abilities and aptitudes of applicants and to place them at work for which they are physically and mentally suited.

5. *In-service training:* An adequate orientation program, including introduction into the hospital and into new assignments, does a good deal to overcome the insecurity and tension which always results when people find themselves in new situations. In-service training is extremely important in facilitating the acquisition of new nursing skills. Management training, including such subjects as human relations, observation and study of human behavior, conference leadership, communication, administration etc., offers tremendous opportunities for improving the leadership skills, of our potential supervisors.

6. *Medical services:*

(a) *Diagnosis and placement:* The early recognition and suitable placement of the tension prone is important in the maintenance of health and good work. Ready access to health counselling services, the preplacement examination and the periodic examination provide important opportunities for preventive work on an individual basis.

(b) *Treatment:* Prevention and case-finding are important parts of the health job. Emotional first aid measures can often prevent breakdowns requiring prolonged therapy. In the average hospital health service, physicians and nurses undertake much more counselling in relation to mental health problems than in relation to organic disease. Their work would be relatively ineffective unless they were students of human behavior.

(c) *Education:* You cannot teach mental health. Assistance in personality development, through counselling, is constructive. Those who like people can readily become students of human behavior and with sufficient experience can learn to interpret the significance of behavior patterns.

(d) *Rehabilitation:* The early and safe return to work following illness, organic or otherwise, is an important consideration in the maintenance of health. Disabling injury or disease al-

ways produces insecurity. The mental health factors are usually the major consideration in rehabilitation programs. They are much more difficult to deal with than organic factors. Rehabilitation following major mental illness is a problem requiring a highly coordinated effort.

That health, morale and efficiency are inseparable is a well-established fact. That the maintenance of emotional health offers the greatest challenge to medicine, psychiatry and to public health, unfortunately has been recognized only within recent times. That a nurse's job, her relationships to her colleagues and to her supervisors are crucial factors in determining her mental health and morale requires much more attention.

L'Evolution de la Cardiologie et ses Problèmes

PAUL DAVID, M.D.

ADOLESCENCE ET AGE ADULTE

IL EST UNE MALADIE de coeur qui par son importance et ses ravages prédomine nettement dans cette période de vie qui va de 5 ans à 40 ans et c'est la maladie cardiaque rhumatismale. Le rhumatisme articulaire encore appelé inflammatoire ou maladie rhumatismale est responsable d'au moins 90% des lésions acquises: sténose mitrale, insuffisance mitrale, sténose aortique, insuffisance aortique, maladie mitrale, maladie aortique, tricuspidite etc. . . . Il est quelques notions qu'il faut retenir, sur lesquelles j'insiste chaque fois que l'occasion m'en est donnée depuis 8 ans, notions qui avec le temps devraient être comprises dans notre milieu si jamais on organise une lutte efficace contre cette maladie.

1. La maladie rhumatismale frappe avec prédilection l'enfance (4 à 18 ans).
2. L'agent causal ou étiologique de la maladie n'est pas connu.
3. On semble avoir établi un rapport étroit entre elle et le streptocoque hémolytique. Pour cette raison, elle succède presque toujours à des infections respiratoires de la gorge et particulièrement des amygdales.
4. La maladie rhumatismale cause des lésions endocarditiques particulièrement des valvules chez au moins 50% des sujets malades.
5. Le rhumatisme articulaire aigu est souvent peu tapageur et donne des symptômes qui passent malheureusement inaperçus pour les parents des victimes et il faut le dire pour bon nombre de médecins qui les traitent.
6. Un traitement précoce et bien conduit en milieu bien surveillé semble diminuer nettement l'incidence des lésions cardiaques consécutives.
7. Nous constatons avec regret qu'aucun effort sérieux n'est fait dans la Province de Québec en vue de nous aider à éduquer la population et nous permettre de mieux soigner cette maladie.
8. Le traitement de la fièvre rhumatismale s'échelonne sur plusieurs mois et repose avant tout sur le repos.
9. Il faudrait un petit hôpital spécialisé où ce traitement pourrait être continué aussi longtemps que persistent les symptômes d'activité avec programme de repos, de distraction et d'étude pour les enfants.
10. Il faudrait que la cortisone puisse être donnée à chacun dès les premiers symptômes sans égard pour son coût élevé.
11. Il n'existe pour le moment aucun moyen certain de diagnostic, aucune drogue absolument spécifique.
12. Il semble que la pénécilline donnée prophylactiquement et sur de longues périodes diminue l'incidence de

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la maladie et empêche les rechutes.

Sachant que l'incidence du rhumatisme articulaire aigu, que les lésions cardiaques et de leurs conséquences sociales sont infiniment plus meurtrières que celles de la polyomyélite, je ne puis m'empêcher de supplier nos services de santé de nous prêter leur concours. Peut-être alors pourrions-nous, quelque part, découvrir une thérapeutique du type "Salk" pour accroître les défenses naturelles de l'organisme contre cette maladie.

Que faire vis-à-vis d'une lésion cardiaque constituée et ceci en général dans les années qui suivent une ou plusieurs poussées rhumatismales? Sur la lésion elle-même aucune drogue n'agit. Les thérapeutiques médicales éloignent les complications, les adoucissent, les préviennent parfois, rien de plus ou de mieux. Elles ne peuvent modifier l'architecture valvulaire d'une sténose ou d'une insuffisance. Force est donc de recourir à la chirurgie des lésions acquises qu'a mise au monde Bailey et son groupe en 1948. Cette chirurgie a fait ses preuves dans les lésions sténosantes, en particulier la sténose mitrale. Cette chirurgie se pratique aujourd'hui dans tous les services importants de cardiologie du monde entier. Notre expérience porte sur 185 patients opérés pour sténose mitrale; 6 patients pour sténose aortique; 1 patient pour insuffisance mitrale et un patient pour sténose tricuspidienne.

Notre premier malade fut opéré par le Docteur Edouard Gagnon à l'Hôpital Notre-Dame en février 1950. Avec cinq années de recul, nous nous sommes persuadés des énormes bienfaits de la chirurgie cardiaque, en particulier de la sténose mitrale où notre expérience est la plus grande. Mais ici encore nous croyons très important de poser des diagnostics très précis et d'éviter à tout prix des opérations inutiles. Sur les 185 malades que nous et nos collaborateurs avons présenté aux chirurgiens, nous comptons deux erreurs, pourcentage extrêmement faible de 1.1% lorsqu'on connaît les difficultés que constitue par exemple l'interprétation d'un souffle systolique de pointe. Il faut réaliser que malgré une intervention réussie la maladie de base persiste et que pour cette raison nous ne prétendons pas guérir ces malades. Notre expérience et celle de nombreux centres a abondamment prouvé que ces opérations prolongent la vie des malades, les soulage de leurs symptômes et les mettent à l'abri des complications habituelles de la maladie pour une période de temps que seul l'avenir précisera.

Age mûr et vieillesse

Je laisse à chacun de déterminer à quelle décade de vie commence la vieillesse. Admettons, toujours pour les fins pratiques de ce travail, que l'âge mûr a ses débuts à la quarantième année. On peut encore exceptionnellement trouver des lésions congénitales, assez souvent des lésions rhumatismales mais la pathologie cardiaque est franchement dominée par les maladies dégénératives: maladie hypertensive d'une part, coronarienne c'est-à-dire angine de poitrine et thrombose coronarienne d'autre part. Cela ne signifie pas que ces deux pathologies ne puissent être rencontrées avant. J'insiste même sur l'impression que nous avons de diagnostiquer des angines et des thromboses chez des individus plus jeunes que l'âge habituellement cité dans les livres et les articles anciens. Il n'en demeure pas moins qu'après quarante ans la majorité de nos cardiaques rentrent dans le cadre de ces deux pathologies.

Hypertension artérielle

Sauf exception, c'est une maladie au long cours qui s'échelonne sur une vingtaine d'années environ avant de donner ses complications cardiaques, vasculaires ou rénales habituelles. La gravité de l'hypertension se juge par le chiffre de la pression diastolique et par ses répercussions sur le coeur et les reins. L'examen du fond de l'oeil permet une évaluation de l'atteinte artérielle réelle.

La cause de cette maladie, en admettant qu'elle fut unique, est inconnue. Il serait trop long et en dehors du cadre de ce texte d'énumérer même brièvement les nombreuses théories édifiées sur ses très nombreuses composantes.

Depuis quelques années, cinq au maximum, le traitement médical donne des résultats qui dépassent les espoirs des médecins les plus sceptiques. De mois en mois s'allonge la liste des hypotenseurs efficaces. Cependant le traitement médical exige des connaissances approfondies car il n'est pas sans danger. Des doses trop petites ne donnent aucun résultat et des doses fortes sont facilement toxiques. De plus, ces médicaments sont très coûteux et les visites médicales doivent être rapprochées. Obstacle sérieux pour ceux dont les moyens financiers sont limités. Ici encore devant la masse des hypertendus, maladie extrêmement répandue, on s'étonne de l'apathie d'action de nos groupements en quête de nouveaux territoires de philanthropie. Evidemment, l'hypertension n'est pas contagieuse mais on sait qu'un facteur héréditaire joue un rôle non négligeable si bien que les hypertendus de demain le seront en large partie à cause des hypertendus d'aujourd'hui. Un traitement chirurgical a sa place dans le traitement de certains cas d'hypertension.

Maladie cardiaque coronarienne

Le drame coronarien peut se jouer en quelques secondes. Il peut durer plusieurs années. Maladie courante qui frappe partout autour de nous, tue subitement les uns, en réduit d'autres à une invalidité physique absolue, ralentit, démoralise toute une masse d'homme et cela particulièrement entre 40 et 65 ans. Maladie dégénérative, pas nécessairement de vieillissement, dont l'artériosclérose sélective sur l'arbre coronarien, diminue le débit du sang qui nourrit le muscle cardiaque. Maladie traitresse que rien ne peut prévenir et que peu de chose peut efficacement arrêter. Ennemi no 1 du male mûr car jusqu'à l'âge de 60 ans trois hommes pour une femme en sont atteints. Nos bureaux regorgent de coronariens et c'est pitié de réaliser comme nous pouvons peu pour eux. Cela ne veut pas dire que nous ne pouvons rien. Ici plus qu'ailleurs doit être appliqué le principe célèbre et vrai du "primo non nocere". L'étude de la crase sanguine, des phénomènes de coagulité et la thérapeutique anticoagulante sont des apports récents de grande valeur et qui solutionnent en petite partie cet immense problème. J'aimerais ici encore voir nos services de santé s'intéresser, comme nous, à ce problème dont l'intérêt pratique est évident. J'ai un parent, et ce cas est loin d'être unique, qui est mort subitement de thrombose coronarienne à 35 ans en se rendant à son travail. Père de famille comme bien d'autres, il a laissé sa femme et trois garçons. Avez-vous déjà songé à ce que la société faisait pour aider, si besoin est, dans de pareilles circonstances? La pension est-elle le seul apanage des femmes et des enfants de soldats morts au champ d'honneur? Chaque homme de ce pays ne concourt-il pas, en temps de paix, à son épanouissement et sa prospérité? On s'occupe des très pauvres et c'est bien mais il faut songer à l'immensité des fortunes moyennes qui se refusent en peinant comme des dérates à déchoir physiquement, moralement et matériellement. La chirurgie tente depuis vingt ans de trouver une solution optimiste à ce problème. Elle est prometteuse mais encore expérimentale. Je mentionne, parce que canadiens, les travaux remarquables de Mercier-Fauteux et ceux que poursuit actuellement Arthur Vineberg dans ce domaine.

Importance Sociales des Maladies du Coeur

1. Les maladies de coeur tuent à elles seules pratiquement autant d'individus que toutes les autres maladies réunies. Quelques chiffres pour confirmer cette assertion: Etats-Unis 52.3%; Canada 43.5%; Montréal 37.2%.

Devant ces chiffres pourtant éloquents, il est curieux de constater l'esprit de fatalisme qui empreint les responsables de nos services de santé, comme s'il était normal de mourir de son coeur, comme si rien ne pouvait être fait.

2. Les maladies de coeur, nous l'avons vu, ne sont pas l'apanage des vieillards, ni d'un sexe plutôt que l'autre. A preuve les statistiques que nous avons compilées sur les malades hospitalisés à l'Institut en 1954.

a) Nombre total de malades hospitalisés ——— 725
Nombre de femmes

hospitalisés 351
Nombre d'hommes
hospitalisés 374

b) Tableau des âges respectifs dans les deux groupes:

Nous constatons que les malades hospitalisés pour leur coeur l'ont été avec la plus grande fréquence — entre 30 et 50 pour la femme — entre 50 et 60 pour l'homme. Réfléchissons un instant sur l'importance économique de ces hommes et femmes, rendus plus ou moins invalides à des âges particulièrement utiles à la société. Ces chiffres démontrent, à mon point de vue, que les cardiopathies sont très loin d'être l'apanage du vieillard.

3. Les maladies du coeur imposent, quelle que soit leur étiologie, une réduction de l'activité physique par l'apparition de deux symptômes dominant: la dyspnée d'effort et la douleur thoracique d'effort.

Imagine-t-on l'importance de ce fait quand la plus grande partie d'une population vit essentiellement sur sa capacité d'effort physique? Pensons à la grossesse, aux soins des enfants, à l'entretien du foyer! Pensons aux conséquences sociales de l'ouvrier immobilisé, du travailleur manuel qui n'a pas eu la préparation ou n'a pas les aptitudes pour devenir du jour au lendemain un collet blanc!

4. Les maladies du coeur sont essentiellement chroniques et elles s'étagent sur des années d'évolution. Par leur chronicité, elles supposent des soins médicaux constants, la prise quotidienne de médicaments, le besoin d'hospitalisations répétées, des arrêts de travail souvent prolongés, des dépenses médicales constantes. Situations qui crée le cortège de tous les drames matériels, psychologiques et sociaux de n'importe quelle maladie chronique.

5. Le cardiaque bien compensé est un "handicapé".

Même lorsqu'il ne ressent aucun symptôme, le cardiaque, avant même de souffrir physiquement subit les ennuis de sa maladie.

L'assurance dont les opérations financières n'ont aucune visée philanthropique refuse systématiquement tout individu hypertendu, coronarien ou porteur d'une lésion congénitale ou acquise. Bon nombre d'assurances-maladies exigent au départ une excellente santé. De plus en plus la grande industrie par le truchement des unions ont créé des fonds de retraite, de pension de maladie etc. Mais, et j'insiste, à l'embauchage le candidat est examiné et seul l'individu sain est admis.

Cependant le cardiaque peut travailler lorsqu'on n'exige pas de lui un effort physique trop considérable. Ne pourrait-on pas lui confier ces multitudes de positions sédentaires qui sont souvent occupées par des hommes vigoureux et sains. Un immense effort est fait dans ce sens par nos amis américains. Les lois les plus élémentaires de la charité chrétienne pourraient jouer dans la plus catholique des Provinces du Canada! Qui mettra sur pied une société ou une association d'aide et d'entre-aide aux cardiaques? Qui s'intéressera au sort de nos malades?

Parce que nous sommes convaincus que notre seul devoir n'est pas de traiter la maladie seulement, nous avons mis sur pied un modeste service social à l'Institut. Mademoiselle Henriette Tenaille, en charge de ce service, essaie d'améliorer les situations les plus désespérées. Notre effort est une goutte d'eau mais il est un témoin de notre préoccupation et de nos pensées.

La Médecine Moderne Coûte Cher

Ne pas l'avouer c'est vouloir intentionnellement cacher une vérité. L'avouer c'est donner raison aux milliers de personnes dont tout acte médical ou hospitalier est jugé sur son prix. Dans les salons, on discute les prix du médecin, du chirurgien, de l'hôpital, d'un test de laboratoire, d'un examen radiologique avec la même passion que les cours à la bourse, les nouvelles créations de la haute couture, le chauffage, le loyer ou les taxes. "J'ai enrichi le docteur Untel de 500 dollars pour me faire faire la grande opération et l'Hôpital de 2,000 dollars. C'est révoltant, le café était froid, j'ai attendu 18 minutes une nuit pour la bassine, j'ai payé pour des tas d'examens inutiles, on m'a fait voir par tout un groupe de spécialistes pour rien." Elle est pourtant bien cette femme aujourd'hui, elle ne souffre plus

et elle ignore peut-être que ces 2,500 dollars l'ont guérie d'un cancer au début. Pour ce prix, elle vivra dix ans de plus, 250 dollars par année, moins que le prix de deux paquets de cigarettes par jour! Le médecin n'est pas un être humain. Il a perdu aux yeux du monde le droit d'avoir une vie de famille, de se reposer, de prendre des vacances et surtout de charger des honoraires. Les hôpitaux sont des asiles de charité qui emploient un personnel formidable et qui devraient boucler leur budget avec les prières des honnêtes gens.

Malgré les exagérations, les jalousies mesquines, les interprétations malveillantes, les connaissances inadéquates des saboteurs du médecin et de l'Hôpital un fait surnage, indéniable: la médecine, surtout hospitalière, coûte cher.

Nous savons qu'un séjour hospitalier pour opération cardiaque coûte au malade qui peut payer un minimum de 2,500 dollars. Mais nous savons également que la même opération ne coûte obsolument rien au patient d'assistance publique qui en plus de ne pas payer le chirurgien, le médecin, l'anesthésie, le radiologiste, l'homme de laboratoire, les gardes-malades des soins post-opératoires contribuera pour un déficit d'au moins 1,000 dollars dans le budget de l'institution. Le calcul est simple. Admettant que ce malade est hospitalisé 30 jours, nous recevons très exactement 30 x $7.50 de l'assistance publique — $225.00.

Evidemment, il y a dix ans, on n'opérait pas sur le coeur et pour cette raison, moins de dépense. Il fut un temps où les rayons X n'existaient pas, où l'électrocardiographie n'avait pas été inventée. Il fut un temps où il n'y avait ni médecin, ni hôpitaux. Il fut un temps où la médecine ne coûtait rien et où on mourrait en moyenne à 30 ans! Ce ne sont pas les hôpitaux, ce ne sont pas les médecins qui coûtent cher, c'est la médecine avec ses progrès, ses raffinements, ses exigences, son désir de poser des diagnostic certains aboutissant à des thérapeutiques sûres. Et la médecine c'est l'étude de l'être humain si complexe qu'il n'a et ne pourra jamais être reproduit sans des cellules mâles et femelles. L'être humain si complexe que malgré des siècles de recherche il demeure "l'homme cet inconnu" de Carrel. Et pour le guérir des innombrables maladies dont il peut être atteint, on critique ces minutieux examens que le médecin, à savoir limité, doit utiliser dans le seul but d'aider un autre être vivant comme lui. La médecine coûte cher. Et l'automobile, le confort de la vie moderne, un avion à réaction, une pile atomique, une seule expérience de destruction dans les déserts du Nevada! Mais j'admets qu'avec les taxes, avec la vie, avec les loyers, le chauffage, les enfants et tout le reste, la médecine coûte cher au gagne petit et à l'individu de classe moyenne, d'autant plus que la maladie est une malédiction jamais méritée et rarement prévue.

Nous nous orientons inexorablement vers une médecine sociale, souhaitable d'ailleurs pour les petits et pour les institutions. Des expériences ont été faites ailleurs, en Angleterre, dans les pays scandinaves, en France pour ne citer que celles que je connais. Il faut admettre qu'en France, en particulier, les sécurités sociales ont grandement aidé le malade sans nuire au médecin. Nous n'avons personnellement aucune objection à une médecine socialisée en autant que soit respectée la liberté du médecin, du malade et de l'institution hospitalière. Nous croyons même que le peuple dont le principal souci est l'insécurité y trouvera réconfort, joie et paix. J'admets volontiers le principe de l'être bien portant payant en taxes pour son frère malade. Je suis de ceux qui croient que la santé est la richesse la plus enviable de chaque être humain. Mais, ne nous faisons aucune illusion, la médecine sociale continuera à coûter cher, peut-être davantage même parce qu'elle nécessitera une armée de fonctionnaires. Elle coûtera moins à chacun et davantage à tout le monde. L'homme continuera à se plaindre mais moins des médecins et des hôpitaux et davantage des taxes. Mais pendant ce temps, le malade lui, sera traité sans avoir un oeil sur la médecine et l'autre sur la portefeuille.

Rôle de l'Institut

En m'écoutant vous avez déjà com-

pris nos buts et saisi quelques-unes de nos réalisations. Nous essayons de faire mieux sans prétendre faire plus qu'ailleurs. Nous n'espérons pas tout découvrir et rayer les maladies du coeur du tableau des maux dont l'homme aura toujours à souffrir.

Nous essayons avec le plus de compétence, le plus de lucidité, d'honnêteté et de dévouement possibles d'aider la cause des maladies du coeur. Notre programme comprend:

Le diagnostic et le traitement des maladies du coeur.

L'enseignement de notre spécialité aux médecins praticiens.

Le désir de prouver l'importance morale et matérielle des maladies du coeur.

Le développement de moyens d'aide et de réhabilitation aux cardiaques.

Le souci de donner à notre population du Québec le profit immédiat des découvertes qui concernent la cardiologie.

Le besoin de posséder toute l'instrumentation nécessaire à la meilleure pratique possible de la cardiologie.

L'obligation de faire de la recherche pratique et basale.

L'essai d'intéresser les services de santé de la Ville, de la Province et du Canada à collaborer avec nous et à nous aider matériellement. Je dois malheureusement souligner un échec complet vis-à-vis des autorités Municipales et Provinciales. Nous pensons un jour réussir en prouvant davantage nos besoins et en expliquant mieux nos buts véritablement, sincèrement et uniquement humanitaires.

Puis-je, mesdemoiselles infirmières, compter sur votre appui moral dans l'édification d'une oeuvre imparfaite mais dont le seul but est d'aider, de soulager les misères de notre frère, le malade du coeur. Compris ainsi, vous réalisez que nous osons dépasser et de beaucoup le seul cadre d'une cardiologie scientifique où seule a de l'importance la maladie. Nous croyons au contraire que le malade et chaque malade seul est important.

J'aurai moins de remords d'avoir abusé de votre très bienveillante attention si ce trop long travail peut avoir contribué à vous mieux faire comprendre quelques-uns des problèmes de la cardiologie moderne.

In the Good Old Days

(*The Canadian Nurse* — FEBRUARY, 1916)

Breast feeding for the first six months is desirable because: (a) The mother's milk furnishes some little known substances which act in a protective way against infections of various kinds; (b) because after a child is six months old artificial feeding is much easier. It has been found that rickets is fairly common among infants that are taken off the breast feedings too soon. Scurvy is also seen though less frequently.

* * *

Quinton, in 1910, advocated the use of sea water plasma to offset dehydration in acutely ill patients. McKenzie, in 1912, went further and used normal saline solution made with sterile distilled water. In thus raising the quantity of fluid in the tissues there is an increased secretion of urine and a resultant increase in the elimination of toxins.

* * *

The training school for nurses represents one of the most important departments of a hospital both because of its function in nursing the patients and because of the public demand for trained nurses. It is an interesting fact that those who organized some of the early schools had a much better conception of the need of nurse training schools as educational institutions than those who are responsible for the majority of the schools today.

Practically every hospital has its training school. In most instances the hospital has established the school, not with any deep-rooted desire to train nurses for the purpose of serving the public generally or because of any particular interest in education along this or any other line, but with one idea paramount — to get the nursing work of the hospital done in the simplest and cheapest possible manner.

* * *

In connection with every large hospital there should be a convalescent home, under public or private auspices, where patients may receive necessary care while convalescing thus relieving the hospital and minimizing expense.

Counterpane Land

LOUISE PRICE BELL

ILLNESSES OF ALL KINDS are as inevitable as taxes when there are youngsters in the family. Parents of today are usually pretty intelligent about the care of their children, make sure that they have proper foods to give them well-balanced diets, that they get a maximum of rest and fresh air. But even with advanced medical knowledge, "sniffles" will occur, the "children's diseases" descend upon the family, and in most families some Tarzan-minded lad is sure to fracture an arm or leg! All these things mean that the child, or children, will be forced to spend some time in bed. For an active smallster this can be a boring, tedious, unhappy period. Or it can make the "Land of Counterpane" a delightful place. The difference rests with the parents, most of all with the mothers.

It is more difficult to keep tiny children happy than it is their older brothers and sisters. Tiny tots can look at pictures, and the dime stores are full of interesting — and at the same time instructive — picture books. Little children always enjoy juvenile records and a new one will often keep them quiet for a long time. These are now inexpensive, and will fit on any record player. In our family — where the number of juvenile illnesses has been lengthy and numerous — we have always felt that the little (or middle-sized) invalid had a priority on both radio and record player if there wasn't one already in the room. When one of our children faced a six-months' period in bed, her grandparents presented her with a record player and one or two records. As time went on and others knew about the gift, a record appeared in the mail from time to time. I mention this as a suggestion that is well worth considering, for when a little sick-a-bed is uneasy a quiet musical number — such as Brahms Lullaby — will often turn a neat trick at eliminating tension.

Mrs. Bell resides in Tucson, Ariz.

For spry young children, a canary, parakeet, or bowl of goldfish will be eye and ear catching, help to make the sickroom cheery, and keep the child happy. In homes where a bird is a part of the domestic scene, it is an easy matter to move it to the child's room. Goldfish and globes are inexpensive and when placed on a table at eye-level for the flat-on-his-back child will keep him alert to the golden flashings through the clear water. Even fish-feeding time will be a diversion! The triangular glass prisms that make up the old-fashioned candelabra that most of our grandmothers had, are fascinating to a child. Carefully remove one from its hook and hang it by a stout thread in the window that gets the most sunshine. As the prism gently sways back and forth in the sunlight, the colorful and elusive "light-birds" will dart here and there on the wall, across the bed, sometimes on the child's eager hands.

Quite small children can handle the wooden beads used in kindergartens and made in the seven standard colors. One of our children learned his colors very quickly through these beads while having the fun of stringing them for his sister to wear. There are colorful design-blocks, too, which also teach color while the child is creating his own designs. And every mother knows how much little children like to "make things" from plasticine. For this task, be sure to cover the bed-table with a piece of plastic or oilcloth to avoid soiling the counterpane, for children can have just as much fun being neat while doing interesting things as they can making more work for mother!

No matter what the age of the child who is ill, some sort of bed table is necessary and if you don't have a *bona fide* one, substitute a card table. Stand two of the table legs on the floor close to the bed, leave the other two folded under the table and rest the opposite side on a firm pillow or blanket. If the table is a Formica-topped one you won't need to cover it;

if not, buy a square of sunny-yellow oilcloth and thumb-tack it on the under side to protect the table. It wipes off easily.

Slightly older girls will adore paper doll cutting and dressing, again materials that are obtainable at the dime store. Boys will have as much fun with the books that involve cutting out and assembling planes, jets, motors and the like. Scraps may be dropped into a waste basket beside the bed or into a laundry or large paper-bag pinned to the side. Tinker-toys are simple building pieces that both boys and girls enjoy, and scrapbooks are always popular. For the latter it is wise to give the little sick-a-bed an objective. Every town has a hospital or orphanage to which the finished book can go. Making a scrapbook as pretty and neat as possible, to be given one who is ill, has a sound psychological effect. The child thinks of someone else and ceases to be sorry for himself, if that has been his attitude.

Simple jigsaw puzzles are fun for all children. For the younger ones, the pieces should be large and the puzzle easy, to avoid frustration. Older children will enjoy the challenge of fitting map puzzles together, placing the countries, states, and provinces in the correct spots. A pleasant way to study geography!

"Picture stories" are fun to make. Give the child a pile of magazines of the type that are filled with colored advertisements and pictures of all kinds. By looking through them he will soon get ideas for making stories from the pictures, filling in a word here and there to make complete sentences. For example, many milk ads have a cow included, so: "A *cow* gives *milk* and eats *grass. Children* drink *milk.*" (The italicized words indicate easily found pictures.)

Older children enjoy making decorative stationery by cutting out flowers, fruit, a plane, a girl-or boy-head, then carefully pasting them to the top of dime-store note paper. This might serve as a future birthday gift for an older brother or sister. Then he can make some for himself upon which to write the important "thank you notes" to friends and relatives who have been nice to him while ill.

If the child has never had a diary, this is a good time to give him one for he will enjoy making entries each day, or night, and doing so will make him realize how fortunate he is to have a home, family and friends who are so kind to him. If he is at all good at making verses, suggest the entries be made in rhyme; this will take extra time since he will want to practice on paper before entering the verses in the "brand-new" diary.

Carving figures from pure white soap is a good idea if the invalid can actually do carving and won't simply "mess up" the bed, thus making extra work. By the trial and error system I know that children can do many things to keep them happy without causing mother extra work — a thing that shouldn't be allowed since illness itself causes extra work. In fact, many children will take pride in trying to save mother from extra steps by using a whistle, or mouth organ, to call her when she is needed. One blow, or toot, can mean "Come when you can," two "Please come now."

Growing things add to the attractiveness of a child's sickroom and the little sick-a-bed can plant a carrot, or sweet potato, in a vase, then watch it grow. One child I know planted six sweet potatoes in cheap vases and when they were at a pretty, green-leafed stage, asked her older brother to deliver them to six people she knew who would enjoy them. Two were other children who happened to be in bed with the mumps and a bad cold, three were older people on the same street, and one was her beloved grandmother.

Mothers should remember that long illnesses *can* bring out selfishness in a child. For that reason the more things that can be done to divert the interest to *others* the better the therapy. Other family members will naturally play Scrabble, Old Maid, Canasta, Parchesi, or whatever the age-level and interest of the child is. But he must not be allowed to feel that he should always accept their offers or he may get to expect too much attention. This is sometimes difficult for a parent to do, but the child will be thankful for this treatment later — you may be sure of that!

What about Vacation Plans?

ETHEL ARMSTRONG COLLINS

WHEN THE CONVENTION IS OVER, give yourself a holiday! Post-convention trips are becoming increasingly popular, and deservedly so. Nurses, of all persons, realize that a vacation is not an expense but an investment, paying dividends in health, happiness, new friendships and memories. Go East or West, north to the rim of the Arctic Circle, to the land beyond the sunset, or down to the South Pacific. See the majestic Canadian Rockies, Banff Springs; incomparable Lake Louise; Jasper Park; Mount Edith Cavell; the Pacific Coast. Sail across the Straits of Georgia to Victoria, stop at the lovely, old, ivy-covered Empress Hotel. See the famous Butchart Gardens and go over the Malahat Drive. Cruise to Alaska or fly to the southern paradise of Hawaii. Or visit the big cities of the East — Ottawa, the Nation's capital; Toronto, Niagara Falls, Quebec and Montreal. Take an inland cruise down the mighty St. Lawrence and up the Saguenay River. The choice is your own. Make it a happy one and have a never-to-be-forgotten holiday. This is not just wishful thinking — all of these trips have been planned and worked out for your pleasure and comfort *and* at reasonable cost! They can all be done within the thirty day return limit on your convention fare to Winnipeg.

Mrs. Collins is Convention Coordinator of the Canadian Nurses' Association, Ottawa, Ontario.

Fairly complete information about these trips was published in the October issue of *The Canadian Nurse*, but it has been necessary to make some changes. The Canadian Pacific Airlines have advised us with regret that they will not be operating the Klondyke Gold Nugget Tour in 1956. The Canadian National Railways have made some changes in the Alaska Cruise. It is now proposed that the T.S.S. *Prince George* will leave Vancouver Wednesday, July 4 at 9:00 p.m., sail up the Inside Passage, make the usual calls at Prince Rupert, Ketch-

(C.P.R. Photo)

Administration Building, University of Manitoba.

ikan and Juneau, and arrive in Skagway Sunday morning at eight o'clock. Instead of remaining in port for 36 hours, as formerly, it will stay only 12, therefore both the West Taku Arm and the Whitehorse Trips must be cancelled. A scenic tour will leave Skagway at 8:30 a.m. for Carcross, over the historic Trail of '98. There will be a stopover at Bennett, and return to the ship at 4:15 p.m. in time for the 7:00 p.m. sailing. Arrive back in Vancouver July 13 at 9:00 a.m.

Those taking the Hawaiian Tour may leave Winnipeg Saturday afternoon, June 30, on a T.C.A. tourist flight, arriving at Vancouver that same evening. The Canadian Pacific Empress Airliner takes off at two o'clock Sunday afternoon for Honolulu, where it arrives at 11:30 p.m. Instead of the Moana Hotel as previously planned, our party will stay at the Halekulani (meaning "House befitting Heaven"). Located in a four-acre cocoanut grove on the beach at Waikiki, it is one of the beauty spots of the Island, where one may enjoy all the comforts of a modern hotel in a delightful setting, typical of old Hawaii. Guests are welcomed with the traditional leis of orchids, ginger flowers or frangipani, and a friendly holiday atmosphere prevails. There is Hawaiian entertainment — dances, music and native feasts — once a week there is a special festival of ancient and modern hula at a colorful buffet luncheon on the Ocean Terrace. The swimming is unsurpassed anywhere in the world. Average water temperature in July is 81°; average air temperature 76°. Step right off the terrace on to the Beach, to sun or swim — to try the thrill of surfing (with an expert instructor), or the excitement of riding the waves in a catamaran or outrigger canoe.

Four sightseeing tours are included in the cost of your trip to Hawaii. Limousines are used and the drivers are friendly hosts as well as informed guides. The *City Tour* takes you into the palace of former kings, with the Throne Room still intact, also to the residence of the late Queen Lilioukalani and to Moanalau Park. The *Circle Island Tour,* through pineapple plantations, sugar cane fields and acres of orchids, includes visits to a Buddhist Temple, a Mormon Temple, the Oahu Country Club, Upside Down Falls, and a poi factory, to mention a few points of interest. The *Koko Head Tour* follows a winding drive along the sea coast, past the Amelia Earhart Memorial, Diamond Head, Koko crater, an extinct volcano, and the Blow Hole. The *Mount Tantalus Tour* gives a breath-taking panoramic view of Honolulu, Pearl Harbor and miles of surrounding countryside. This trip includes tea at the old Waiola Tearoom and a visit to Robert Louis Stevenson's Grass Shack. There are many other sightseeing trips that can be taken if one desires, also there are daily flights across to other islands.

Certainly it provides a wonderful holiday with never a dull moment. As one member of our party expressed it in 1954, "No matter what happens now, I have been in Paradise." Wearing many leis, we will say a sad "Aloha" to the Friendly Islands, and board our plane on Thursday evening July 12, arriving back in Vancouver Friday morning.

Because these tours come at the height of the busy summer season, may we urge you to *please get your reservations in early.* Also, from recent experience we are reminded that PRICES AND TIMES ARE SUBJECT TO CHANGE.

People whose way of living has not changed for many centuries are free of certain diseases that take many lives in modern countries. For example, of 80,000 Jews who emigrated from the ancient land of Yemen to Israel, researchers found that not one had diabetes, or other degenerative diseases. The scientists were struck by the fact that there was no hardening of the arteries even among those over 45 — the age when other peoples begin to suffer heavily from this disease.

A special study was made of 300 immigrants, all over 45. Their bodies were free of cholesterol, a chemical regarded as the primary cause of hardening of the arteries. After two years in Israel, the cholesterol levels in their bodies rose but remained lower than those found in western peoples. And there was still no sign of degeneration of their arteries or other organs.

— (ISPS)

In Memoriam

Elizabeth Jane Bowie, a graduate of Lady Stanley Institute, Ottawa, died suddenly October 26, 1955. Miss Bowie served with the C.A.M.C. during World War 1. Following her release from the service she worked in Kingston, and later was on the staff of Ste. Anne's Military Hospital, Ste. Anne de Bellevue, Que.

* * *

Edith Grace (Bishop) Clark who graduated from Prince Edward Island Hospital, Charlottetown, in 1926, died at her home in Tarryburn, N.B., on October 28, 1955, after a lengthy illness. For many years she worked at the New Rochelle and Wickersham Hospitals, N.Y., before engaging in private nursing at the Saint John General Hospital, N.B.

* * *

Jean Cormie, a graduate of Oshawa General Hospital, passed away at her home in Fergus, Ont., on October 12, 1955.

* * *

Patricia (Bazanet) Farrell who graduated in 1946 from St. Michael's Hospital, Toronto, died there on June 24, 1955.

* * *

Ella Forbes, formerly a resident of Nova Scotia, died in October, 1955, at Gimli, Manitoba.

* * *

Evelyn Elizabeth (Gouldie) Hawke who graduated from Women's College Hospital, Toronto in 1939, died in November, 1955. Mrs. Hawke was with the Sangamo Co. Ltd. as plant nurse for ten years.

* * *

Cynthia Pauline Horsnell, a graduate of Victoria General Hospital, Halifax, died at Berwick, N.S. in November, 1955. Miss Horsnell served on the staffs of Fraser Memorial Hospital, Kentville and Highland View Hospital, Amherst. Later she was supervisor of the nursery at Grace Hospital, Ottawa. Prior to her illness Miss Horsnell was on the staff of Stratford Hospital, Ont.

* * *

Lucille Laura (Ross) Stanley-Jones, formerly of Seaforth, Delaware, died in Vancouver, November 16, 1955. During World War 1, Mrs. Stanley-Jones served as a nursing sister with the French Red Cross Society.

Jemina Leckie, a graduate of Mount Clair General Hospital, New Jersey, died at London, Ont., on October 29, 1955. She worked a number of years at the Delaware Water Gap Sanitarium and later nursed in Detroit, Toronto, Goderich and London. At the time of her retirement she was matron of the Belleville nurses' home in New Jersey. She was 90 years of age.

* * *

Daisy (Grant) MacIntosh, a graduate of an American Hospital died suddenly at Stellarton, N.S. on November 13, 1955.

* * *

Margaret McDermid died on October 31, 1955, at London, Ont. Miss McDermid helped to organize the first public health nursing course at the University of Western Ontario.

* * *

Bernadette (Walsh) McDermott, who graduated from St. Michael's Hospital, Toronto, in 1919, died there on October 4, 1955. For some time she engaged in public health work and private nursing.

* * *

Rose (Kemmet) McDonald, who graduated from St. Michael's Hospital, Toronto in 1905, died in that city on July 28, 1955. Prior to her marriage she was engaged in public health nursing.

* * *

Margaret Elizabeth (Hunter) Pedlow, who graduated from the Royal Victoria Hospital, Montreal, in 1947, died in Vancouver on November 9, 1955. She was 32 years old.

* * *

Kathleen H. Walker, who graduated from St. Joseph's Hospital, Toronto in 1930, died suddenly at her home in Islington, Ont., on November 1, 1955. Miss Walker had done staff nursing for 10 years before assuming the position of supervisor of public health nurses in York Township.

* * *

Caroline (Kennedy) Watts, who graduated from a Winnipeg hospital in 1897, died in Nelson, B.C., at the age of 94. At one time she served as matron of Kootenay Lake General Hospital and performed outstanding nursing work during the influenza epidemic of 1918.

L'éducation consiste dans la croissance, le développement de l'être humain jusqu'à l'état parfait d'homme comme tel, qui est l'état de vertu. — St. Thomas d'Aquin

NURSING SERVICE

The Role of the Industrial Nurse in Accident Prevention

THERESA GREVILLE

NURSING, IN GENERAL, tends to be associated in the minds of most people with a smiling patient in a nice, neat bed with an attractive nurse (preferably red-haired) standing by . . . or, the more dramatic shots of men and women in white, gowned and masked, cheating death in an operating room.

The industrial age and the tempo of our times, combined with increased knowledge of disease prevention, have brought medical and nursing teams into every aspect of living and working. In addition to all of the work done in hospitals we have public health nurses, nurses in every branch of the Armed Services, nurses in the sky and more recently parachute rescue teams with Para Nurses.

Occupational nursing, a branch of public health nursing, "is the application of nursing skill to groups of men and women at their place of work for the purpose of helping them build and maintain their best health and to render prompt, efficient nursing assistance when they are ill or injured at work." (McGrath)

The ideal nurse for this work is one who has a willingness to continue her education throughout her working life. She should have a mature personality with a knowledge of psychology and a liking for working people. She should know or learn something about compensation laws, union agreements, hospitalization and medical plans as they affect the place where she works. She should be aware of community resources available in matters of health and welfare. She needs to be prepared to render first aid and have special ability, judgment and knowledge so that she will route patients to the hospital, clinic or doctor, when necessary. She needs to know her role in disease prevention and the correct maintenance of records.

The first known literature on occupational diseases was published about 1703 by an Italian doctor, Bernardine Romanizi. Since that time and particularly since about 1890, occupational health has been of prime concern to governments, medical men, nurses, employers and employees. Nurses in industry have ferreted out the needs and with the assistance of the groups concerned, the "sanitation of the environment" has been improved.

THE SAFETY PROGRAM

Accident prevention has become increasingly important to the nurse. In the *Journal of Chartered Insurance Institute,* published in England, there is a report by T. A. M. Pirrie in which he says:

> There are two main reasons why accidents should be prevented: They cause suffering; they cause material waste.
>
> The amount paid to the injured person is only part of the financial loss. The services of the man have been lost which often means that a new man has to be engaged and trained. If the injured man was skilled, it may be difficult to

Miss Greville is chief of nursing staff, Canada Packers Ltd., Winnipeg, Manitoba.

replace him. It may be necessary to shut down machinery so that an investigation may be held. Men in other parts of the plant lose time discussing the accident. Employees who saw it may be shocked and their work suffers accordingly. In short, the effects of an accident on production can go on being felt for a long time after it happens.

Management is not hard to convince of the importance of accident prevention. It is often the foreman and charge hand who have come up through the ranks who fail to grasp the importance of safety work. Those in charge of departments must be made to realize the responsibility that rests on them, and clearly understand that they are judged not only on the output of work but also on freedom from accidents. The foreman in turn need the cooperation of all the employees in working safely and pointing up danger areas. An operator can become so familiar with his machine that he sees no danger in its working parts. Yet there are avoidable accidents that have resulted in heavy financial loss to the firm and worse than financial loss to the victims, for who can put a price on human life and limb? No one has yet discovered how to grow a new arm or hand and plastic surgery cannot completely cover up the scars. Surely it is up to us to protect industry's most valuable asset — the man on the job.

How does the nurse assist in the accident prevention program?

By an awareness of the goals of safety committees, and by cooperating with them to bring hazards and job complaints, as they relate to safety, to their attention.

By the day by day instruction of patients reporting to her, teaching each one the importance of preventing infection and disablility by prompt attention to and follow-up care of minor injuries and illnesses. Other forms of instruction include reaching people through the plant magazine, bulletin boards and health literature racks.

By allaying apprehension. Rehabilitation starts with the first treatment. The nurse's attitude, while being realistic, must allay all fears as far as possible.

By recognizing emotional or physical disabilities that may lead to accidents unless corrected; by realizing that certain conditions and diseases, such as those caused by alcohol, poisons, virus or bacterial infection, dietary deficiency, Parkinson's disease, multiple sclerosis, are fairly common. People suffering from them do not have proper physical control of themselves and are liable to more accidents than physically normal people. The employee suffering from such disorders should be referred for medical care and, with as little mental disturbance as possible, be made to realize that because of his handicap he must exercise more caution.

By realizing the effects of fatigue, whether caused by sleeplessness — T.V., broadcasts of games, the noise of planes or diesel engines — by the second job, skylarking, or the emotional strain due to sickness, discord or financial difficulties in the home.

She should work towards good personnel relationships. Dr. P. J. Moorad, U.S. Consultant in Psychiatry, writing in *Industrial Health*, about Human Factors in Accident Liability, states that "A new employee is often introduced to his job and department by unfavorable comments and fearful stories about his work. He is, therefore, psychologically predisposed to accidents. There is too much fooling around in industry, too much picking on the weak. There are more practical jokesters than supervisors and management realize. These are not healthy situations. The sensitive are constantly ill at ease, tense and anxious as to what will be done to them next. With a man's mind so taken up with irritation and annoyance by men around him, he cannot be a safe worker." The doctor recommends that practical jokesters, bullies and wise guys be exposed and dealt with as a plant responsibility in the interest of health and safety.

The nurse should probably not head up the Safety Committee because participation in safety work brings education to a greater number of workers either at the supervisory or unskilled level, but, she should participate in all ways possible to further the work of such committees and so create a happy and healthy work situation for all workers from the executive of the company to every member of the work team.

Schizophrenia

ANN STEWART

INTRODUCTION OF PROBLEM

JUDY ARRIVED at the Allan Memorial Institute one Sunday evening, escorted by two policemen. She was an attractive fifteen-year old, neatly dressed in slacks and a raincoat. She had applied her make-up with a generous if slightly unskilled hand. She showed no outward sign of her recent bizarre behavior.

When she was shown to her room on the ward, she quickly lay down on the bed assigned to her. Her eyes were wide and staring, her face devoid of expression. Although she appeared mute, she seemed to be well aware of her immediate surroundings. She lay with her head extended in an awkward, seemingly painful position and soon became irritable and moderately negativistic to the doctor's insistent questioning. That evening, she appeared ill at ease in the company of the other patients in the room and remained unresponsive to their friendly approaches.

It is of interest to note that, although she had seemed, to her parents, to be behaving in a very peculiar manner for the previous week, they had left her in the company of an older sister for the week-end. It was while they were absent that she was found wandering about the streets by the police.

PHYSICAL CONDITION

My patient, the seventh youngest of eight siblings, had been a premature baby. Her mother, a plump, middle-aged woman did not have a difficult delivery. Before the age of one, the patient had struggled through four consecutive bouts of pneumonia, but she seemed to progress fairly well after her first year and measles was her only other childhood disease. Excepting for removal of tonsils she had never had any operation, accidents or peculiar habits.

Judy was a slight but wiry adolescent who weighed 90 pounds on admission and stood five feet, three inches tall. She had been known to complain of her flat-chested condition to her mother and sisters, and was quite indignant that her clothes did not fit so well as other girls. She frequently complained of headache during the year prior to coming to hospital. Although there was no definite evidence of hallucinations or delusions, she was quite openly apathetic, listless and displayed indifference that passed into mute catatonic states fairly readily. As previously mentioned she was often irritable and negativistic.

About a week following her admission, she complained of pain just below her right ear and was seen by the doctor who assured her that there was nothing there to worry about. During visiting hours, she was very demanding of attention from her parents and later while sitting at the supper table suddenly began to cry "Oh my head!" and to extend her head in an awkward, crooked position.

She rushed to her room, insisted on seeing her doctor again and attempted to leave the building when he didn't arrive immediately. When he came she appeared mute and hostile, but seemed slightly reassured. Eventually she was persuaded to eat her supper and to participate in the ward's evening activities to a small degree. Although no further mention was made of this particular discomfort, there have been other episodes when the complaints have been headache, constipation, earache or abdominal cramps. Each time she was carefully examined by the doctor, but nothing was discovered.

Miss Stewart, who graduated in 1955 from Royal Victoria Hospital, Montreal, prepared this study while on affiliation at the Allan Memorial Institute.

Social History

Judy recently entered high school. Bilingual and generally first in her class, she had not been allowed as a small child to play with her friends anywhere excepting on the balcony of her own home. When these restrictions were relaxed my patient formed many new friendships. Her mother described Judy as enjoying the company of her many schoolmates and she seemed to socialize easily.

Her father was a slightly-built man of medium height. Superficially he seemed meek and timid, acting sheepishly in the company of strangers. When he was visiting his daughter he never spoke while the nurse was in the room. This unfortunate man has an intense fear of dying or even suffering the slightest physical injury.

In contrast her mother was an anxious, concerned, middle-aged woman. Due to her unhappy, impoverished home life, she has suffered several mild depressions, but she constantly tried to bring about peace in the distraught household. One brother, 18 years old, has recently come under psychiatric treatment.

Her mother described Judy's behavior, particularly in the past year, as erratic, irritable and highlighted by frequent outbursts of temper. She would suddenly demand something — very frequently new clothes — and would fly into a fit of anger if her whim was not indulged immediately. Intensely jealous of her now happily married older sister, throughout the sister's courtship, Judy would become violent and throw articles about the room. She insisted she wanted the living room to herself whenever her sister was visited by her fiance. Actually, Judy was quite shy and ill at ease with boys and said she has an aversion towards them.

Judy had always shown a fanatical desire for new clothes and was jealous of her older, working sister who was able to have a larger wardrobe. She spent considerable time getting dressed and applying make-up, gazing all the while at her reflection in the mirror. She felt she was built more like her father, would have liked to appear older than her age and wondered why she did not look like her young friends who were better proportioned than she. This feeling of awkwardness and self-consciousness might easily be due to her age. Fifteen is a time for personal misgivings on the part of any youth.

This family was Roman Catholic but my patient did not seem particularly devout. There were no medals or prayer books in her belongings at the hospital and she never, to my knowledge, asked to see her priest on her own initiative.

It became evident that Judy was having difficulty in school, where previously she had done well. Feeling that her teacher and the students were laughing at her, she tended to isolate and seclude herself. Finally she absolutely refused to attend school, stating she wanted to punish her parents. Until the time of her admission, her behavior went steadily downhill. There was open withdrawal of interest in her schoolmates, loss of ambition in her school work and indication of obvious feeling, thinking and behavior disorders. Frequently she would insult her mother and sisters with coarse, vulgar expressions then suddenly turn and kiss them, begging their pardon. These outbursts were most apparent preceding and during her menstrual periods which had been fairly regular since their onset several years before. Inconsistently, she would refuse what was given to her, although she had previously asked for it. She would take what was not hers, threatening suicide if her wishes were not granted.

The Thursday prior to her admission, Judy stayed in bed, refusing to eat. At four o'clock in the morning she attempted to leave the house, crying "Nobody loves me, nobody wants me." She hit and kicked her mother, who tried to calm her. Eventually she returned to bed where she slept all through the next day.

Supportive Care

Nutrition: This was a major problem with Judy, particularly when she was put on coma insulin and it was imperative that she have a well-bal-

anced diet. Constant encouragement and persuasion were required to bring her to the dining room, where she would sit and stare disdainfully at her food. She enjoyed fluids, particularly tea, but her appetite after her treatment was exceptionally poor. The family, with obviously good intentions, brought her fruit, candy and cookies, but these were put aside and soon forgotten.

How We Attempted to Overcome This Problem:

a. Throughout the earlier part of the day, after the coma insulin therapy, we offered frequent small meals. This was the schedule:

10:30 a.m. — (or at the time of completion of treatment) fruit juice, toast and jam, tea.

12:00 a.m. — a meat sandwich and milk.

2:30 p.m. — ice cream, fruit juice.

5:00 p.m. — supper with the other patients.

8:30 p.m. — milk and sandwiches.

b. The confections brought by her mother were kept in Judy's refrigerator and offered to her after a meal so that they would not spoil her appetite.

c. We tried to avoid hurrying Judy either to come to meals or to eat, in an attempt to overcome the tension which inhibits the appetite and delays digestion. To do this, I would approach her about 15 minutes before the meal was to be served, giving her ample time to apply make-up and care for her hair, then walk in a leisurely manner to the dining room.

d. Frequently the nurse on duty would use power of suggestion — for example, the sight and odor of food; leaving the food in an accessible place without comment after placing a spoon in her hand.

e. If possible, we placed Judy at a table where her companions ate at a leisurely pace and it was unnecessary for her to compete with faster-eating people.

f. We tried not to fuss over her too much, at the same time we did not allow her to dawdle over her meals long after everyone else had finished.

Sleep: The difficulty here was Judy's desire to withdraw from the environment. She would remain in bed all day if left to herself. We encouraged her to be about during the day so that she would sleep well at night. She seldom required evening sedation.

How We Went About This Problem:

a. We tried to keep her out of her room as much as possible. As soon as she had finished her meal, we asked her to join us while we watched T.V. or participated in some ward activity. The suggestion of occupational therapy sometimes was effective. She sometimes spent the afternoon sewing.

b. A walk out of doors proved to be refreshing and invigorating.

c. It was essential that the nurses worked as a team, encouraging her and preventing her from slipping away from being with others.

Personal Hygiene: My patient, unable to always sense her physical needs due to her slowed-down mental state, depended in part on the nurse for personal cleanliness and appearance. Such particulars had to be cared for without making her feel conspicuous. If the results drew some expression of approval from the other patients and nurses, it was a good tonic for her.

How We Attempted to Approach This Matter:

a. After her treatment in the morning, we prepared a bath or shower to freshen and brighten her. Brisk rubbing with coarse bath towels aided in stimulating circulation. Having been generously supplied with bath powder and deodorant by her family, these articles were laid out for her and she applied them daily.

b. Laying out her tooth paste and brush generally was sufficient reminder to care for her teeth; if not, putting the tooth paste on her brush served to guide her. I usually left a plastic glass by the sink and offered a glass of water to her whenever I was in the room. A glass of mouthwash, offered before her meal, relieved any sour taste present in her mouth.

c. We tried to encourage her to go to the bathroom at regular intervals. She generally had a bowel movement about every second day, but was inclined to be negligent about her regularity. Offering fruits throughout the day, as well as some sort of daily exercise, helped her overcome this problem.

d. As an adolescent, she had the usual troubles with her complexion. Her skin was quite oily so it was important to remind her to wash her face with soap and water frequently. Applying cold cream to her lips, which were often cracked or chapped, softened them considerably. Reminding her at bedtime to remove her cosmetics and wash her face was helpful. Although she loved to look at herself in the mirror, she frequently forgot to care for herself.

e. We tried to encourage her to keep her comb and brush clean. Since she washed her hair every weekend while she was at home, it was a simple matter to care for it during the week. She arranged the short, naturally curly hair very attractively with some assistance.

f. Laying out her emory board and nail file on her dresser after her morning bath taught her to care for her nails.

g. We noted the duration and flow of her menses. We offered her the sanitary pads on the ward and assisted her in local cleanliness and sanitation if she required help.

h. Since she loved clothes, particularly new ones, we guided her in the care of her personal articles. It was important for the nurses to cooperate with each other in developing Judy's interest in her personal hygiene and teaching her hygienic procedures whenever the opportunity arose. We helped raise her self-respect by a well-placed compliment, our own personal example and expressing admiration of the good hygiene carried out by other patients or nurses.

Protective Care

Suicide: Although I realize that anyone emotionally upset is potentially suicidal and that my patient had threatened on several occasions before she came to hospital to end her life, I believe that it was done to attract attention and to punish her parents. During her hospital stay it was more of a problem to prevent her leaving without permission. She did not threaten or attempt suicide, to my knowledge, while here. The precautions that we took to avoid injury to the patient were the same as for prevention of suicide.

It is to be noted that the physical environment of the hospital offers the security that is one of the patient's greatest needs. Security that can be depended upon, a routine that is reasonably the same from day to day, contact with a limited number of persons, removal from significant persons who have been the cause of some of their difficulties, relieve patients of the necessity of making decisions and of the many demands of usual existence.

Injury to Herself and to Others:

Several days after admission, Judy while taking a shower turned on the hot water faucet too swiftly and as a result received a bad scare. Luckily she was not burned. It was a blunt reminder to the staff that this little girl needed keener surveillance.

Precautionary Methods to Prevent Injury:

a. On admission we routinely check through all the patient's belongings. Any sharp things are kept in the office, to be given to the patient if required for a short period of time and then returned to the office. Matches are kept only by the nurses and the patients are not allowed to smoke in their rooms. It is helpful to remind the relatives that the patients are not allowed to retain these articles while in hospital.

b. After coma insulin treatment, Judy was unsteady on her feet, requiring staff assistance to prevent her from bumping into furniture or tripping over objects. We ran her bath or shower for her and were nearby in case she required help.

c. Hazards such as waxed or wet floors can be treacherous to a preoccupied patient, so we guided her around those obstacles.

d. Laundry chutes, kitchens, bathrooms except in the morning were kept locked as well as the utility room, linen

room and nurses' office with all the medical supplies. The doors at either end of the ward were kept locked at night. No cutlery or glassware was allowed in the rooms. The windows open only a few inches from the bottom.

e. If Judy was too strongly antagonized by some well-meaning, but thoughtless patient, she might easily have acted impulsively and hurt this person. She also needed protection, both physically and psychologically, from other more aggressive patients. It was wise for the nurse to anticipate such occurrence and to be on the alert for any impulsive and un-self-disciplined act.

Leaving Without Permission:

Judy made several attempts to run away. When her hostile, negativistic manner was more emphasized than usual it was a danger signal to the staff.

How We Prevented These Incidents from Occurring:

a. By being alert to recognize her increased hostility, thus anticipating her desire to leave.

b. Judy was both insecure and uncertain so that one of the most effective measures to promote a sense of security was consistency in the nurse's attitude. A routine was offered that gave her something to depend upon. Thus we avoided making promises to her that we knew could not be carried out — e.g. a promised visit home that did not materialize.

c. On her admission to hospital, the various privileges and limitations were explained to her. At the patients' group meetings the head nurse frequently gave a reminder of the precautionary rules of the hospital — e.g. boundaries of the hospital grounds.

d. Reporting accurately and promptly to the head nurse or interne, both orally and on the chart, any unwarranted change in the patient's conduct.

Social

Socialization: The tendency of patients to withdraw into a world of phantasy from situations where they must socialize is very persistent. Perhaps Judy felt that her contacts with other people had been fruitless, her family and friends had let her down or just did not understand her. Obviously she was so preoccupied at times, we knew she was not giving us her attention. When we spoke to her she might or might not respond.

How to Counteract This Problem:

a. The nurse must be consistent in her attitude — friendly, but firm, realizing that it is her responsibility to bring her patient into contact with everyday living.

b. Since in her preoccupation, Judy might respond to our approach with irritation, we must realize that we have probably diverted her attention from something that was pleasant to something that was annoying. I tried to circumvent Judy's irritation by appealing to her suggestibility. For example, laying her clothes out on her bed so she would dress and be prepared for the day at the same time as the other patients. We also avoided her antagonism by seldom touching and never pushing her about.

c. Since most people like to be warned about what to expect in a new situation, it was important to explain new procedures to her as well as to introduce her to a new roommate.

d. My seeking out of this patient at every opportunity conveyed my interest to her. Just sitting quietly beside her for brief, but consistent periods conveyed this message. There were many one-sided conversations, generalizations that did not require answers. Eventually one could feel her warming to sympathy and she would offer a comment of her own.

e. Due to the coma insulin therapy she received, she was only able to be at occupational therapy in the afternoon. After strong persuasion from the staff and friendly patients she started and took obvious delight in making a pink felt elephant. Later the staff was unable to encourage her to attempt something else.

Judy seldom conversed with other patients. Her uneasiness on the night of her admission had been reduced to a mere apathetic interest. Generally it

was only after a weekend at home that we might see her coming to watch television on her own initiative, or perhaps share a few words with someone.

Observation: The extent of the patient's progress is often shown by the nurse's observations, carried out in a manner that will cause the patient no discomfort or concern.

Direct Observation:

a. Notice the patient's facial expression, this may often correspond to her emotions.

b. Note whether her mood is appropriate to the situation or is consistent with her behavior.

c. Observe her movements and choice of activity.

d. Note how she adapts to the environment — is her manner indifferent? Does she identify others accurately and indicate that she knows what day, time and place it is?

e. Describe her daily habits — personal hygiene, care of personal property, appearance, industry. Note any bizarre, unusual behavior. If she has been mute for a long period, then relate the circumstances that lead up to her breaking her silence.

f. Describe her speech, the expression of feeling, any memory defect.

g. Note her choice of companions. Does she frequently demand to see the doctor, refusing the nurse's assistance?

Observation by Participation:

Frequently I dropped by the occupational therapy department and chatted with the patients and therapists, at the same time, observing my patient for:

a. Extent of pleasure and enthusiasm in work.

b. Expression on her face — did she seem engrossed in her work? Did she seem contented or bored?

c. Her ability to do the work — did she seem to take pride in her handiwork?

d. Did she concentrate well?

e. Was she there of her own accord? Did she soon show signs of fatigue?

f. Had her ability improved since her last visit to occupational therapy?

g. In order to observe my patient's appetite, I could assist in the dining room without making the patients feel uncomfortable — helping to seat them, pouring milk and tea, passing cream and sugar and anticipating special requests. I noted my patient's manners and her consideration for others at the same table. Did she eat her food in the regular order? Did she socialize at all or concentrate all her efforts on eating?

h. By playing a card game or working a jigsaw puzzle with my patient, I would note: her ability to play fair — was she a good sport or a poor loser? What of her ability to learn new games — her confidence in herself?

i. How did she behave when her family visited her? What were her feelings before and after their visit? Did she seem to enjoy their company?

j. Her behavior throughout any treatments.

Rehabilitation:

It is rather unusual to note that according to her parent's description, when Judy was allowed to go home she socialized quite readily and entered with enthusiasm into the home duties such as baking or sewing. While she was at hospital her seclusiveness and negativism continued to be quite evident. It appeared that her condition improved considerably when she was in the home atmosphere.

As a nurse, I tried to adopt a teaching pattern for helping my patient prepare for her eventual return home. I carried out this plan by:

a. Offering a stimulating environment for the learning of new skills. Association of the patient with her roommates who were on the same treatment as herself, offering new recipes for cooking which she enjoyed doing at home, and reading fashion magazines, were ways to interest her.

b. By my example my patient might learn a great deal. I had to keep in mind that my appearance, manner and attitude might be beneficial or harmful.

c. Repetition of new ideas and skills until they were firmly fixed in her mind.

d. Above all the reassurance of an understanding nurse, interest in her as a person, attention to matters that are important to her helped her attain her

goal. Attention was focussed on the value of day-to-day experience, acquirement of good health habits, including a balanced program of work and play. It must be remembered that she was a young girl who became ill during her adolescence, never a very easy time for anyone. She will require the guidance and counsel of her parents, doctors, nurses and teachers to prepare her to lead a normal life.

Prognosis and Future Plans

Although Judy's improvement was not very startling, her parents felt that while she was at home she was perfectly normal and quite able to resume her normal activities without hesitation. They believed that our doctors were being fooled by her attitude in hospital. In the doctor's words, "she was suffering from a very serious illness, coming on at a critical time in her life and that unless she had the full course of therapy, it was unlikely she would remain out of hospital for prolonged periods of her life."

What I Have Gained

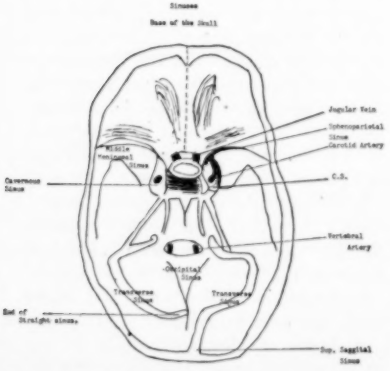
Through this study of Judy and by the nursing care I gave her, I have gained insight into psychiatric nursing. Now I realize what the words "persuasion" and "patience" mean in relation to a preoccupied and hostile adolescent. Perhaps it has helped me understand myself a little better, my limitations, and my way of solving conflicts.

Cavernous Sinus Thrombosis

C. Lawton and M. Hobin

The patient was 20 years of age, and had been a normal, healthy girl until one day she developed a sore, infected spot in her nose. Nothing was done about this as it appeared only a mild ailment.

The following day the girl complained of dizziness, nausea and general malaise. She was found to have a temperature of 102°F. She went to bed and was given an injection of penicillin by a relative who was a graduate nurse. Her condition gradually became worse so the following day a doctor was called and she was admitted to hospital.



Cross-section of the base of the skull showing sinuses

On admission the patient was vague and drowsy, but extremely restless and showed definite signs of profound toxemia. Her face was discolored with proptosis in both eyes.

A complete blood count revealed:
- White blood cells 30,800
- Hemoglobin 72%
- Red blood cells 3,800,000

A spinal tap showed:
- White blood cells 912
- Red blood cells 22
- Pandy's positive
- Cultures sterile.

A nose culture showed:
- Gram positive cocci, moderate growth
- Staphylococcus *aureus*
- Coagulase positive.

She was sensitive to Chloromycetin, less sensitive to Penicillin.

By 8:00 p.m. the patient was semi-conscious — temperature 105°, pulse

This material was presented by the authors, as a clinic at the Sarnia General Hospital.

100, respirations 20. A cold water enema was given and cold packs applied continuously. These succeeded only in reducing the temperature temporarily, and were discontinued two hours later when the patient's temperature returned to 105° and she commenced to have chills.

10:30 p.m.: She was very cyanosed and was placed in an oxygen tent. The pulse was rapid and of weak volume, respirations shallow, and her face now appeared more swollen and red. She did not respond to stimuli. An airway was inserted and suctioned as necessary.

6:30 a.m.: The patient was completely unconscious.

9:30 a.m.: A tracheotomy was performed as a precautionary measure against tracheal edema, respirations appeared a little easier on return to her room. Very little change was noted during the next few hours, although the temperature dropped to 100°, pulse 112, respirations 28.

6:00 p.m.: The patient's pulse became much weaker, color extremely poor and respirations shallow.

Despite a rigorous course of antibiotics, which we will now outline for you, the patient died at 7:35 p.m. three days after the infection first appeared in her nose.

Medications and Treatments

Immediately on admission an intravenous of glucose 5% was commenced and kept running continuously. The following were given by means of the intravenous:

Sulphadiazine gm.4.0 stat. and gm.2.0 q. 6 h.

Aureomycin 500 mgm. q. 4 h.

Chloromycetin gm. 0.5 for 2 doses

Ilotycin gm. 1.

Heparin was also given and doses adjusted according to the clotting time which was taken q. 3 h.

Three spinal taps were performed and each time one million units of penicillin and streptomycin 900 mgm. were injected intrathecally.

Penicillin 1 million units was given q. 2 h. intramuscularly and streptomycin 500 mgm. q. 6 h.

It was suggested that Cortone might help to relieve cerebral edema and so 100 mgm. was given intramuscularly into each hip.

When the condition of the patient worsened coramine 5 cc. was injected intravenously every 15 minutes, with only temporary response.

Summary of Autopsy

The findings are those of infection of the nose, and edema of the nose, eyelids, and upper lids, with thrombosis of the left cavernous sinus, involving the circular sinus and the right cavernous sinus, with extension to the middle cerebral veins, superior petrosal veins, and the pterygoid veins, with infection, compression, and edema of the upper part of the midbrain, and the extension of the infection into the basi-sphenoid and the embolic spread down to the jugular veins to the lungs where there were numerous abscesses.

The cultures taken prior to death, and the areas examined after death have all grown coagulase positive staphylococci in pure culture.

Cause of Death

Brain stem damage, due to thrombosis of both cavernous sinuses following an infection of the nose with subsequent pyemia to the lungs.

Check Points for Canned Food Buyers

Government supervised grade marks on all canned goods are the first thing to watch for when making a selection. Buy nationally advertised brands unless you are familiar with particular smaller companies. Other check points are:

1. Avoid containers that show dampness, drippings, rust and bulging ends.

2. Listen for sizzling sounds of escaping air when first puncturing the can.

3. Take a deep smell for characteristic aroma immediately on opening container.

4. Drain contents and observe inside of container for color. Darkened can indicates long storage.

5. Taste for characteristic flavor and added ingredients.

— *Canadian Hotel Review and Restaurant*

NURSING EDUCATION

With our Training We can Help

EMILY GROENEWALD

THE PATIENTS ON WARD X, all of them ambulatory, were neglecting their customary morning activities. Usually one or two would be pondering over an unfinished jigsaw puzzle. Another might be putting the finishing touches on a leather wallet, inwardly glowing at the thought of the pleased surprise of the occupational therapist when she saw his neat and even stitching. One could almost always guess with accuracy that the patient reading with apparent absorption or concentrating on the writing of a letter was a recent admission to the ward. Conversation among the patients, as a rule, included the current athletic sport, their experiences on active service, or their ear, nose or throat ailments.

This morning they were unusually silent but most observant and alert. There was a new centre of interest on the ward. Finally, courage overcame mere curiosity. Addressing one of the three girls, who were making their beds and tidying their bedside lockers, one of the patients said: "That outfit you are wearing is a new one on me. Now just who and what are you?"

"I am Miss White," was the timid answer, "and we are the first class to take the nursing course now being given at this hospital. This is our first day on the wards and," gaining more confidence as she sensed the friendly interest of the patient, "I feel — sort of funny inside."

"Now, never you mind, Miss White, before you know it you'll be through your training and become a head nurse or a top-shot of some kind."

"Oh, no Mr——? Jones? Mr. Jones — you have to be a graduate nurse to become a head nurse."

"But did'nt you say you are taking a nursing course?"

"Yes," replied Miss White, "But we are training to be nursing assistants."

At this stage two of the other patients had drawn closer and the trainee, finding it difficult to cope with her audience and to concentrate on her work as well, released the tension she was applying to a drawsheet and devoted her attention entirely to the conversation. "We do not learn nearly all that a graduate nurse learns and our course is not as long either, but with our training we can help on the wards. We can do some of the treatments for some of the patients under the supervision of the registered nurse or, under the direction of the doctor, give nursing care to some patients in their homes."

It was on a morning in October, 1952 that the above conversation took place on one of our wards selected for preliminary ward experience for our trainees. The first class was enrolled in the Department of Veterans Affairs' School for Nursing Assistants at the Queen Mary Veterans Hospital in Montreal, in late September of that year. Two other such schools are located at the Sunnybrook Hospital, Toronto and at the Camp Hill Hospital, Halifax. The D.V.A. Schools for Nursing Assistants were organized by Miss A. J. Macleod, director of Nursing Services, D.V.A. and Miss Marjorie Russell, nursing consultant to the D.V.A. Each school has a full-time teaching staff of three graduate

Miss Groenewald is director of the Montreal Central School for Nursing Assistants, Queen Mary Veterans Hospital, Montreal.

nurses with special preparation in teaching and supervision. Part-time instructors, who are specialists in their field, give instruction in the care of children and in elementary nutrition.

Our original teaching unit, here at the Queen Mary Veterans Hospital, was in a temporary building known as "Hut 10." With regret, almost, we must explain that the walls of our hut were not of clay, nor did it have a thatched roof.

On December 15, 1954 we moved into our spacious and elegant quarters in the new wing of the hospital. Reader, have you ever moved? If so, you will be smiling sympathetically. Not only do all those packing cases and boxes so carefully marked and labelled lose their distinguishing features en route but there seem to be twice as many of them when they are finally unloaded at their destination. While striving to appear cheerful and briskly competent in the midst of aforementioned unfamiliar packing cases, dismantled beds, unassembled bookshelves, etc., two snow-covered trees were dragged in! But of course, the school always has a gala Christmas party complete with a tree under which are placed the gifts, brought in under "the-draw-a-name-buy a-seventy-five-cent-gift" system, which Santa Claus jovially gives out to the surprised recipients.

We are proud of our well equipped teaching unit consisting of a lecture room, library, demonstration room, diet laboratory, sitting room, locker room, and offices. Visitors assure us that our color scheme is most attractive. Against the backgrounds of various pastel shades the trainee in her distinctive short-sleeved yellow uniform, (with the D.V.A. insignia on the arm band) worn with a white bib and apron, organdy tie-back cap, and brown shoes and stocking makes a pleasing picture. Patients often refer to them as buttercups, daffodils or canaries.

Classes are enrolled twice a year. Trainees range in age from 18 to 40 and must have completed at least one year of high school. Creed, race, color or marital status does not bar an applicant though we emphasize the fact that home or other responsibilities must not interfere with attendance during the ten months of the course. Language difficulties? Yes, indeed —

Qualified to Help.

but in coping with these difficulties both instructor and trainee become quite resourceful. During the early weeks of the course one might have to demonstrate a hiccough to explain the meaning of the word. When one is informed that the coccyx is in the "downstairs region of the spine" one is definitely not disheartened!

The curriculum is based on the recommendation of the special committee of the Canadian Nurses' Association, and meets the requirements for certification in Ontario. Subjects taught in the school are elementary nursing, hygienic housekeeping, elementary biology, personal and community health and hygiene, elementary nutrition, adjustments and interpersonal relationships, care of mother and baby, care of children, first aid and bandaging, civil defence. In accordance with a resolution passed by the Committee on Educational Policy of the Canadian Nurses' Association, the basic course has recently been strengthened by emphasizing psychiatric aspects of nursing within the present outline.

The first four months of the course consist of theory, demonstration and practice in the classroom, and orientation to clinical areas and special departments in the hospital. As soon as a new procedure has been satisfactorily performed by the trainee in the demonstration room she is taken to a ward where she carries out this procedure under the supervision of an instructor from the school. Wards are selected and the trainees are given additional assignments as they progress. By the fourth month of their training they spend about three hours on the wards daily.

At the beginning of the fifth month the trainee starts her full-time ward experience. In addition to the Queen Mary Veterans Hospital the following hospitals participate in our training program: The Montreal General, Royal Victoria, St. Mary's, Queen Elizabeth and Jewish General. Each trainee spends four weeks at the Montreal Children's Hospital, two weeks in a nursery, two weeks on a maternity ward and approximately twelve weeks on medical and surgical wards in one of the above-mentioned hospitals. The trainee is under the supervision of a member of the teaching staff of the hospital involved and of the head nurse of the ward to which she is assigned. An instructor from the school acts in the capacity of visiting clinical coordinator. Evening and/or night duty is limited to three weeks as supervision, individual and group clinical instruction and proper evaluation of trainees present problems, in most cases, during these hours of duty. Trainees are required to do "observation" studies on two or more patients during their term of full-time ward experience.

Directors of nursing in the participating hospitals act in an advisory capacity to the director of the school. Their interest and support is deeply appreciated and is most encouraging.

Graduation, which follows on the heels of final examinations, is for us the great day just as it is everywhere for anyone in any way involved with students. Sixty-two nursing assistants have successfully completed the course at the Queen Mary Veterans Hospital. With pride, though, we speak of 210 graduate nursing assistants. In April 1954, the Montreal School for Nursing Assistants, established in 1948 under the direction of Mrs. F. Fisher, amalgamated with our school and thus came into existence "The Montreal Central School for Nursing Assistants" as we are now officially known.

And after graduation? Excerpts from letters received from, and from conversations with, graduate nursing assistants tell their own story:

"This is a 20-bed hospital in a 500-peopled town. Most of the people are of Ukrainian origin and I have already learned seven words in that language. The work is rewarding and interesting. We have so many opportunities to do the things we were trained to do."

"When Mrs. S. goes to hospital I am going to look after Mr. S. and the two small children and I shall be staying on for one week longer when Mrs. S. comes home with the new baby."

"There are four graduate nurses and the three of us at this Camp for Crippled Children. Under the direction of the nurses we take care of the more severely handicapped children and also take part in the recreational activities of the camp. We are having an interesting and enjoyable summer."

"I am learning so much about the care of the patient with tuberculosis and have gone up the coast by plane on 'escort duty'."

"My patient's husband seemed so helpless and lost when I first came here. He is 74 and she is 70 — the cancer is quite advanced. I let him help me with the housekeeping duties and even with some of the nursing duties, and now he does not seem quite so sad."

In the home, in small hospitals, in outlying communities, and in our hospitals in the city, the trained nursing assistant is taking her place on the nursing team and is proving her value. With a feeling of the worthiness of work well done in her own field, she shares in and relieves the professional nurse of some of the duties required of the nursing profession as a whole. In the words of Miss White "With our training we can help . . ." Under the direction of doctors and nurses they are helping to assure total nursing care of the patient and helping to maintain and promote the standards of the nursing profession.

New Autoclave Tape

A Toronto nurse is credited with assisting greatly in the commercial development of a new autoclave tape that provides immediate identification of sterilized bundles and items in hospitals. The tape is employed for closing and sealing bundles prior to placing them in the autoclave or steam oven for sterilization. It is now in use in major Toronto and Montreal hospitals as well as in a number of hospitals across Canada.

A query by Phyllis Norton, supervisor of the Central Supply Room in the Toronto Hospital for Sick Children started months of research. She was looking for a new method of sealing wrapped items and a simple means of identifying them after processing. The product had to meet the qualifications of hospital sterilizing. The tape used had to withstand prolonged exposure to steam without losing its body and coming loose. It had to peel off readily without leaving a sticky residue. It had to adhere to all types of dry, clean surfaces such as linen, muslin, plastic, glass and metal. It had to have a backing that would take and hold markings through prolonged heat exposure.

After months of developing tapes that were passed on for testing, a product was devised which not only stood up under the steam and heat exposure, but adhered firmly long after processing. It could be stamped, written on with ink, pencil or crayon. The identification neither ran into the tape or material nor showed any sign of fading.

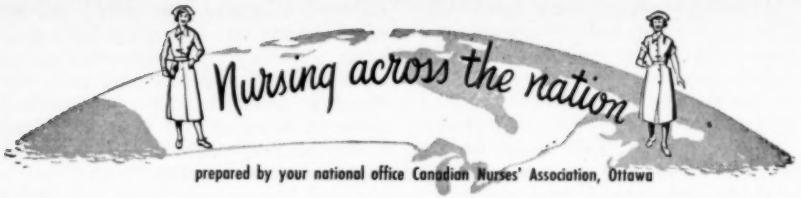
The problem of indicating whether or not a bundle had been sterilized still remained. The final result is a marking that will become visible only after processing under the proper combination of heat and steam. Neither heat nor steam alone nor direct exposure to sunlight will register.

PHYLLIS NORTON

The autoclave tape is economical to use, because only short strips are needed to seal sizeable bundles. One 60-yard roll will seal approximately 720 bundles at an average sealing cost of six bundles for one cent. Because the packages are neater and more compact, they require less shelf space. A hazard of handling bundles is eliminated because there is less danger of accidental opening.

He listens to good purpose who takes notes. — DANTE

The most unhappy of all men is he who believes himself to be so.



Nursing Education

SHOULD THE CNA BE GIVING more direction in regard to curriculum development? Are the various experimental programs under way in different parts of Canada really meeting the needs of nursing? These are some of the questions being asked by nursing educators. At its meeting in January, 1955, the CNA Committee on Nursing Education began a discussion on curriculum, but it was soon evident that constructive, far-sighted work could not be attempted until certain information was available. For, to advise on such matters, one must have a knowledge of the kind of worker which it is proposed will result from the educational program. Objectives must be clarified before curricula can be planned.

With this in mind, each provincial nursing education committee was asked to prepare a statement of its beliefs in regard to the "Philosophy, Aims and Objectives of the Basic Nursing Education Program." This was not an easy assignment. We think we know the goal towards which our teaching is directed, but when we attempt to put these thoughts into words they become very elusive.

The provincial committees have worked long and hard to prepare their statements. One province arranged a full day's conference for this purpose and produced a most comprehensive summary. Their approach was first to consider the general philosophy of curriculum development and, then, through small groups to consider the philosophy, aims and objectives of curriculum as it relates particularly to nursing education. Although at the time of writing, the CNA Nursing Education Committee has not studied the statements, it is possible to say that the theme which runs throughout them all is the importance of the human element — to the student herself, to her patients, to the community, to her co-workers. We seem to be unanimous in realizing that, in order to meet her responsibilities, the nurse must have an opportunity for personal as well as professional growth.

Ninth WHO Assembly

The Ninth World Health Assembly which will be held in 1956 has selected as the topic of the technical discussions "Nurses: Their Education and Their Role in Health Programs."

The International Council of Nurses and the International Committee of Catholic Nurses and Medico-Social Workers have been invited to attend these sessions as international non-governmental organizations in official relationship with the World Health Organization.

The I.C.N. has invited the affiliated national nurses' associations to promote discussion of the topic and to forward a summary of statement based on three broad questions:

I. What is the present role of nurses in meeting the health needs of people?

II. What do nurses see as their future role in (or contribution to) the total health program?

III. What conditions, attitudes or educational facilities should be changed or developed so that nurses may successfully play the role envisaged?

It is our hope that the summary statement prepared by the CNA will appear within the pages of *The Canadian Nurse* at a later date.

Pre-registration for 28th Biennial

Almost daily now pre-registrations are being received in National Office. Student forms are arriving minus names. The lucky girls who will be coming aren't named yet, but none-

theless everyone is entering into the spirit of the Convention. The registrants from Quebec seem to be in the majority. Remember, early registrants will naturally have a better choice of accommodation and the opportunity to choose the post-convention tour of their liking.

The Executive Meeting

February is a busy month at your National Office. With its arrival come the numerous committee meetings which are a prelude to a Biennial Convention.

February 2, 3, and 4 find the Executive Committee meeting at the Chateau Laurier in Ottawa. Some 35 members of the Executive will be in attendance. These members are your elected representatives from all parts of Canada.

Here the reports of the five national committees will be presented and important developments discussed and voted upon. As an example, the Publicity and Public Relations Committee Report will ask the Executive to vote upon the recommendation that the Public Relations Guide prepared during this biennium be printed in both French and English. If this is agreed upon, the Guide will be ready for distribution during the Biennial Meeting in Winnipeg. This Guide is designed to give each nurse helpful suggestions in communicating with other professional personnel and with the public in general. The development of good chapter meetings is discussed within its pages for it is here that the nurse develops her understanding of the profession and what it is trying to accomplish in terms of improved nursing service.

The Program Committee will have much to report as plans are finalized for the 28th Biennial Meeting. Details will be outlined concerning the various sessions, speakers announced and entertainment activities finalized by the Arrangements Committee which is composed of representatives from our hostess provinces, Manitoba and Saskatchewan.

Hospitalization

Have any of you who are reading this been hospitalized lately? Have you been the patient instead of the nurse? We know of a nurse who recently became a patient for a few days. Amazed by the number of people who came popping in and out of her room, she began to keep count.

Within the first twenty hours of her stay in hospital no less than 14 representatives of the nursing team approached her bedside — the supervisor, seven registered nurses, three nursing assistants, three ward aides. Add to this the patient's doctor, two internes, a cleaning woman and a handy man who came in to do a few repairs, it was rather confusing even to a nurse, to say nothing of a person unfamiliar to hospital ways. Do you know that *not one of these members of the nursing personnel offered to introduce herself?* Better communications are definitely needed within our profession.

Le Nursing à travers le pays

L'éducation en Nursing

L'Association des Infirmières Canadiennes devrait-elle donner plus de directives concernant le programme d'étude? Les programmes actuellement à l'essai dans diverses parties du Canada répondent-ils vraiment aux besoins de la profession? Voilà des questions que se posent les éducatrices en nursing. Lors de la réunion de janvier 1955, les membres du Comité de l'Education en Nursing amorcèrent une discussion sur le programme d'enseignement mais on se rendit bientôt compte qu'il était impossible de travailler d'une manière constructive et prévoyante à moins de posséder certains renseignements. Avant de pouvoir donner des conseils sur la préparation d'un programme d'enseignement, il faut savoir d'abord quelle formation l'on vise à donner et quels sont les objectifs à atteindre. Tenant compte de ce fait, l'on a prié chaque comité provincial

d'éducation en nursing de rédiger un exposé de la philosophie, des buts et objectifs du cours de base en nursing. La tâche assignée n'était pas facile. Nous croyons connaître le but vers lequel nous dirigeons notre enseignement mais lorsqu'il s'agit de concrétiser notre pensée par des mots, c'est bien moins simple.

Les comités provinciaux ont travaillé ferme et longuement à la préparation de cet exposé. Dans une province, l'on a organisé, à cet effet, une journée d'étude et on a présenté un résumé très au point. On a d'abord considéré la philosophie générale de l'élaboration d'un programme d'enseignement après quoi, des petits groupes se sont formés pour étudier la philosophie, les buts et objectifs d'un programme d'étude relativement à la formation de l'infirmière. Bien que le Comité national de l'Education en Nursing n'aie pas encore étudié tous les rapports présentés par les provinces, l'on peut déjà déduire que le facteur humain en est l'élément fondamental considéré par rapport à l'étudiante d'abord, puis à ses malades, à la société et aux personnes qui travaillent avec elles. Toutes semblent unanimes à réaliser que pour pouvoir assumer des responsabilités, l'infirmière devrait avoir autant l'occasion de développer sa personnalité que d'acquérir des connaissances professionnelles.

La 9ième Assemblée de l'OMS

La neuvième assemblée de l'OMS, qui aura lieu en 1956, a choisi comme sujet de discussion : "Les infirmières, leur formation et leur rôle dans les programmes de santé."

Le Conseil International des Infirmières et le Comité catholique international des infirmières et des assistantes sociales ont été invités à cette réunion, à titre d'organisations officielles non-gouvernementales.

Le Conseil International des Infirmières a invité toutes les associations nationales à faire connaître leur point de vue en les priant de répondre à ces trois questions :

I. Quel est le rôle actuel des infirmières en ce qui concerne les besoins de la collectivité, en matière de santé ?

II. Quelle sera la contribution des infirmières de l'avenir dans le programme sanitaire ?

III. Quelles conditions, attitudes ou formes d'enseignement devront être modifiées ou développées pour permettre à l'infirmière de remplir avantageusement le rôle que l'on attend d'elle ?

Nous espérons que le résumé préparé par l'A.I.C. paraîtra prochainement dans l'Infirmière Canadienne.

Assemblée du Comité Exécutif de l'Association des Infirmières Canadiennes

Février est un mois bien rempli au secrétariat national ; dès les premiers jours, se tiendront les réunions des divers comités, en vue de la préparation du congrès biennal.

Les 2, 3 et 4 février aura lieu au Château Laurier, à Ottawa, l'assemblée du Comité Exécutif qui réunira 35 membres venant des diverses provinces et étant les représentantes que vous avez élues.

Les rapports que présenteront alors les cinq comités nationaux feront l'objet de discussions et les membres seront appelés à voter pour ou contre la recommandation qui sera faite par le Comité des Relations extérieures à savoir : que le guide préparé par ce comité soit publié en anglais et en français. Si cette recommandation est acceptée, le guide pourra être distribué lors du congrès de Winnipeg. Ce guide servira à apporter à l'infirmière des suggestions qui lui seront utiles dans ses relations avec les autres membres de la profession et le public. Un chapitre est consacré aux assemblées de districts car c'est là que l'infirmière apprend à connaître la profession et la valeur de ses services pour le plus grand bien de tous.

Le Comité du programme présentera un rapport intéressant sur l'organisation de la 28ième assemblée biennale. Des détails seront donnés sur les diverses séances, les conférenciers et les réunions sociales, par le comité d'organisation comprenant des représentantes des provinces hôtesses, la Saskatchewan et le Manitoba.

Inscription préliminaire 28ième Congrès Biennal

Presque tous les jours recevons-nous au secrétariat national des inscriptions pour le Congrès ; les formules des étudiantes-infirmières ne portent pas de noms ; celles qui auront la chance d'assister au congrès ne sont pas encore nommées ; toutes ont l'espoir d'être choisies et ont déjà l'esprit du congrès. Les inscriptions reçues du Québec sont les plus nombreuses. Rappelez-vous que les premières inscrites auront un meilleur choix de logement et de participation aux voyages et excursions organisées après le congrès.

Hospitalisation

Y en a-t-il, parmi nos lectrices, qui ont

For the well-being
of your patients

TAMPAX

intravaginal protection
during menstruation.
Three absorbencies.

CANADIAN TAMPAX
CORPORATION LIMITED
Brampton, Ontario

été hospitalisées, dernièrement? Vous est-il arrivé d'être la patiente au lieu de l'infirmière? Nous connaissons une infirmière qui a, récemment, été hospitalisée pendant quelques jours. Etonnée par le nombre de personnes qui entraient et sortaient de sa chambre, elle se mit à les compter. Durant les premières 24 heures, pas moins de 14 personnes du personnel hospitalier sont venues dans sa chambre — la surveillante, sept infirmières, trois auxiliaires et trois filles de salles. En plus, son médecin, deux internes, une femme de ménage et un ouvrier qui vint faire quelque réparation. Si c'était un peu embrouillant même pour une infirmière que dire d'une personne qui n'est pas familière avec ce milieu? Savez-vous qu'aucune de ces personnes ne s'est présentée! Il n'y a pas à dire, nos relations professionnelles ont besoin d'être améliorées.

Chez les nôtres

La rédactrice de l'Infirmière Canadienne et sa collaboratrice Mlle S. Giroux offrent à tous nos lecteurs leurs meilleurs voeux de Bonne et Heureuse Année. Elles remercient très sincèrement tous ceux et celles qui ont collaboré aux pages françaises de cette revue.

Annual Meeting in New Brunswick

THE MEMBERS OF THE New Brunswick Association of Registered Nurses were guests of the Moncton Chapter at their 39th annual meeting on October 19 and 20. The two-day meeting, held in the auditorium of the Hôtel-Dieu de l'Assomption, was attended by 165.

The first day's meeting opened with the president, Miss Grace Stevens, in the chair. The second day's meetings were chaired by the first vice-president, Miss Lois Smith. The highlight of the morning was the presentation of the first association life membership to Miss Alma F. Law, past secretary-registrar, who on her retirement had held office for 13 years. The citation was given by Miss Marion Myers.

In her presidential address, Miss Stevens spoke of the progress made in nursing education in New Brunswick through the appointment of Miss E. Kathleen Russell to study ways and means of organizing nursing education to give more adequate nursing service.

Following the report of the Committee on Finance, a motion that the annual active membership fee be increased from $10.00 to $12.00 was passed unanimously. The Nursing Service Committee presented some changes in Recommended Personnel Policies which were accepted.

The educational program of the meeting centred on public relations and following the report of the Committee on Publicity and Public Relations, a rôle-playing presentation of various situations met with in hospitals was given under the direction of Miss H. Jean Lynds.

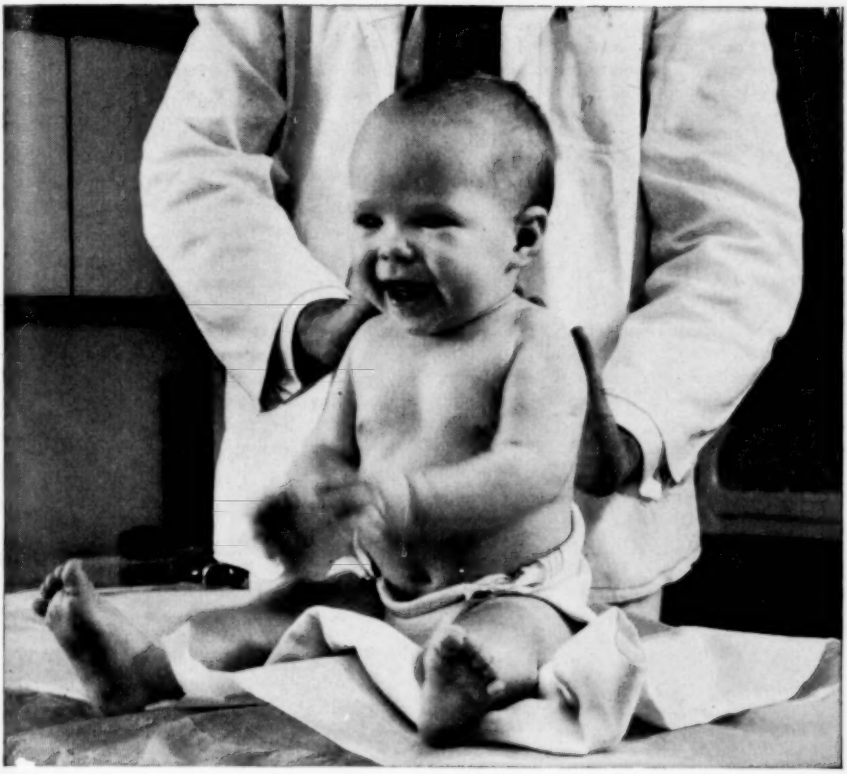
We were fortunate in having as our guest from National Office, Miss Rita MacIsaac who spoke on internal communications. Her topic "It's Up to Us" served to round out the program on public relations and gave a wealth of information on the relationship of the individual nurse to her provincial, national and international nursing organizations, with guidance for successful public relations.

The report of the Committee on Nursing Education noted that some projects which need to be studied will remain pending until the results of the nursing survey are made public in the fall of 1956. A recommendation that the New Brunswick Association of Registered Nurses set aside the sum of $2,000 for the purpose of student loans was accepted.

Miss E. Kathleen Russell was introduced to the members and spoke of the research being conducted as a cooperative effort. She said that there was need for a firmer recognition of the depth and breadth of nursing services demanded today; that the aim of the research was to find recommendations in order to produce more nursing service, more adequate nursing service, and nursing service to meet all the demands of nursing.

The Committee on Legislation and By-Laws recommended that legislation for the auxiliary nurse be delayed until after the research project on nursing education is completed. Provincial office was authorized to charge $1.00 for an endorsement and $2.00 for a complete transcript in completing registration credentials.

Other committee reports of provincial interest were given. Reports from the eight chapters showed a range of activities and interests, with many vital topics and active participation in educational programs by the members themselves.



"Meat....may be fed at any age"

JEAN AND MARRIOTT'S statement in 1947 in their book "Infant Nutrition" that "Meat appropriately prepared may be fed at any age" has been reinterpreted many times since in the light of clinical evidence.

Liverton & Clark (J.A.M.A. *134*,1215 (1947) show that infants of six weeks readily accept and benefit in terms of hemoglobin concentration and erythrocyte count, from a formula which increases their protein intake by 25% by the addition of Swift's Meats for Babies.

Swift's Meats for Babies are prepared from fine lean meats, specially precooked to retain their high nutritional values, and strained to a custard-like consistency. There are seven varieties, beef, veal, heart, liver, liver and bacon, pork and lamb. Swift also prepares Egg Yolks for Babies, Salmon Seafood for Babies, and Chopped Meats for Juniors.

Meats for Babies

SWIFT'S

most precious product

SWIFT CANADIAN CO., LIMITED.

At the annual dinner held at the Brunswick Hotel, John Fisher was guest speaker and delighted his audience with his wit and general Canadiana philosophy.

Prominence was given to the coming CNA biennial at Winnipeg through the showing of a film, and a pep talk by Miss MacIsaac.

The officers of the Association remain unchanged, and are: President, Miss Grace Stevens; first vice-president, Miss Lois Smith; second vice-president, Mother Bujold; honorary secretary, Sister MacKenzie.

MURIEL ARCHIBALD
Secretary-Registrar

Sélection

L'enfant à l'hôpital

Observons l'enfant à l'hôpital, dans cet entourage étrange pour lui, calme, propre, blanc, tout en ordre; dans cette ambiance tellement opposée à son caractère d'enfant, lui qui a besoin de mouvement, de vie, de bruit, d'un peu et parfois de beaucoup de désordre. Il subira des traitements divers, piqûres, lavements, soins de plaies opératoires, sans parler de l'intervention elle-même. Il risquera d'être seul pendant de longues heures. Il aura mal parfois, et personne ne sera près de lui pour l'aider à mieux supporter ce mal. Oui, assurément, l'hospitalisation est une épreuve réelle pour l'enfant. Et surtout pour le petit de moins de 5 ans, alors que souvent, malgré les explications fournies, il ne réalise pas pourquoi on l'a abandonné en ce lieu inconnu et apparemment hostile.

Il en est ainsi surtout pour la raison suivante: l'enfant — et surtout le petit d'âge préscolaire — vit essentiellement dans *le présent*. Il est incapable d'anticiper et d'envisager ce séjour en clinique comme un événement passager. Et son désespoir en est d'autant plus grand. Ainsi, lorsque sa mère l'a quitté, pour lui, c'est comme si elle n'existait plus. L'enfant de 6 ans et plus acquiert progressivement la notion du futur; l'épreuve lui en est facilitée. Il sait qu'il rentrera chez lui. Toutefois, pour les grands enfants aussi, l'épreuve est réelle et il faut les aider à la supporter.

L'intervention, si elle a lieu, est évidemment le point crucial du séjour à la clinique. Il est souhaitable que les parents restent près de l'enfant avant et après l'opération. Il se sentira ainsi un peu plus en sécurité. Cette journée-là est pour l'enfant, comme pour les parents, une épreuve. L'enfant a besoin de la présence d'un de ses parents, de sa simple présence. Il ne demande pas à jouer. Il ne demande pas de bruit. Mais il n'aime pas être seul. La proximité d'un être familier — calme et qui le réconforte — lui est une aide considérable.

LES VISITES

Faut-il rendre visite à l'enfant? Non, nous a dit une mère de famille, "cela ne sert à rien et ca l'énerve. Quand nous ne sommes pas là, il est calme, et dès que nous arrivons, ce sont des hurlements..." En fait, la mère disait cela parce que les hurlements en question l'indisposaient très fort, et qu'elle ne réfléchissait pas au vrai motif de ces pleurs. "Non" vous diront également certaines infirmières, en employant les mêmes arguments. "Dès que les parents arrivent, ma salle d'habitude calme, s'emplit de pleurs et de cris. C'est affreux!"

Eh! oui, c'est affreux... Souvent les enfants pleurent! Mais pourquoi? Ils pleurent pour se libérer de toute l'angoisse accumulée pendant les heures de solitude. Et s'ils demandent encore et toujours à leurs parents de les emmener, c'est parce qu'ils n'aiment pas vivre dans cette salle d'hôpital. *Il semble certain, au contraire, qu'il faut rendre visite à l'enfant hospitalisé, et aussi souvent que possible.* Que faire s'il pleure? Il faut laisser passer le flot de larmes, et quand l'enfant se calme peu à peu, jouer avec lui, lui donner un petit cadeau qui lui dira que l'on a pensé à lui, même en son absence. Que les parents lui parlent de la maison, de l'école, qu'ils lui disent qu'on pense à lui, qu'on sera heureux de le retrouver au foyer... Ainsi l'enfant sentira que les liens avec sa vie habituelle ne sont pas rompus, qu'on l'aime et qu'on ne l'oublie pas.

Il faudra évidemment observer les règlements en vigueur à la clinique. Si les visites

---

Extrait de la revue *L'Enfant* éditée par L'Oeuvre Nationale de l'Enfance de Belgique.

A picture of satisfaction—and why not? This baby loves its Farmer's Wife, and mother knows that the formula milk recommended for her baby was prepared especially for infant feeding and infant feeding alone.

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sont autorisées pendant toute la journée, il est possible d'organiser des visites répétées par différents membres, bien choisis, de la famille: parents, grands-parents, frères et soeurs... Il est très important de ne pas tromper l'enfant quant à la fréquence des visites, de ne pas le faire attendre en vain. Son sentiment de sécurité serait encore ébranlé. Quelle est la durée optimum des visites à un enfant malade? Eh! bien, ici cela dépend de nombreux facteurs: âge de l'enfant, personnalité des parents, gravité de l'affection, occupations ménagères ou autres, de la mère... Il semble cependant que la présence de sa mère ou de quelqu'un de bien connu soit pour l'enfant un élément favorable.

N.B. Nous regrettons ne pouvoir citer que ces quelques lignes de cet intéressant article écrit par le Docteur E. Alfred Sand de l'Université de Bruxelles.

Portrait Unveiled

At a ceremony on November 15, 1955, a posthumous portrait of Miss Mary S. Mathewson, assistant director, School for Graduate Nurses, McGill University, 1936-46 and director of nursing of The Montreal General Hospital, 1946-53, was unveiled by Miss Norena S. Mackenzie, president of the Alumnae Association of the School of Nursing. Miss Mackenzie, who was a close friend and professional associate of Miss Mathewson, paid tribute to the unique qualities which resulted in her outstanding contribution to the fields of nursing education and public health.

Posthumous portrait of Mary S. Mathewson, B.Sc., by Robin Watt, M.C., A.R.C.A., unveiled in Livingston Hall, The Montreal General Hospital.

Miss Ann Peverley, who acted as chairman, stated that the portrait was undertaken in response to requests from friends and colleagues in many parts of the world, and has been made possible by their contributions. Mr. W. S. M. MacTier, president of the hospital, in accepting the portrait, expressed his appreciation on behalf of the Board of Management.

At a reception following the unveiling ceremony, the coffee table was presided over by Miss Rae Chittick, director, School for Graduate Nurses, McGill University, and Miss Mary Ritchie, Assistant Chief Nurse Department of Health, City of Montreal.

New Spectacles Aid the Deaf

Spectacles with built-in hearing aids have been developed as the result of recent advances in the making of miniature electronic components. The battery for the new aid is the size of a dime. Known as the "Spectaphone," the new hearing aid uses a transistor. It marks 30 years progress in the search for an efficient and unobtrusive hearing aid. To solve the problem of coordinating the production of the aid with the older craft of spectacle-making and fitting, selected agents will carry stocks of partially completed frames in a range of sizes, and assemble them when the eye prescription is filled. Many styles will be available to suit wearers in different regions, and the range will be adjusted to meet average sizes and shapes of heads. The Spectaphone is manufactured by Fortiphone Ltd., 247 Regent Street, London, W.1., England.

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Book Reviews

Textbook of Physiology, by Caroline E. Stackpole, A.M., and Lutie Clemson Leavell, M.S. 418 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1953. Price $5.00.

Reviewed by Irene Feely, Science Instructor, General Hospital, Brantford, Ont.

This book has evolved from the authors' appreciation of "certain fundamental problems that confront students of physiology, regardless of their primary interests."

The eight problems, which provide the titles for the sections that comprise the book, are: 1. Maintaining a balance between rest and exercise, work and play. 2. Maintaining an awareness to the environment. 3. Maintaining circulation. 4. Maintaining a constant oxygen supply. 5. Maintaining the protective mechanisms of the body. 6. Maintaining the nutrition of the body. 7. Maintaining the fluid and electrolyte balance of the body. 8. Perpetuating the human race. These sections are subdivided into convenient lengths for teaching purposes.

The information is laid down in a direct manner. It is aided frequently by comprehensive tables as well as diagrams, some of which should encourage students to develop this useful way of retaining or expressing knowledge. The terms used are familiar to students using anatomy and physiology texts of which these writers were co-authors.

Consciousness of the "problem-solving approach" was noted in the preface, and in the questions following some chapters. The customary introduction of "examples" lends reality to the subject. To appreciate this book of physiology the student nurse needs a basic core of anatomy. There is sufficient anatomy provided for recall to make it an interesting and worthwhile study or reference source for nurses, and, in topics of general interest, to orient a reader with a particular interest.

A Manual of Psychiatry, by K. R. Stallworth, M.B., Ch.B. 314 pages. N. M. Peryer Ltd., Christchurch, New Zealand. 2nd Ed. 1953.

Reviewed by Miss Pearl Graham, Superintendent of Nurses, Ontario Hospital, New Toronto, Ont.

This manual has three definite objectives: (1) To provide valuable information for the general practitioner regarding psychiatric patients; (2) as a guide to students of psychiatry; (3) to disprove the belief that psychiatry is a specialty rather than a necessary part of medicine. All objectives are accomplished fairly well. Since technical terminology is at a minimum, the book is of value to laymen also.

It is divided into 28 chapters. Eight of the earlier chapters deal with etiology, routines, classifications and mental hygiene. Chapters 9 - 16 cover types of illnesses, neuroses, deficiency, epilepsy, psychopaths and psychosomatic medicine. The last three chapters deal with treatment and nursing measures. Definitions are simple but excellent. "Intelligence is the ability to profit by experience, to grasp essential meanings of past experience and apply them to the future."

The author stresses the fact of "contagion" in dealing with heredity and environment. The chapter on mental hygiene has valuable suggestions for the preventive side of psychiatry. Treatment data is clear although methods vary in different centres. However, the explanations given will allay the fears of the general public.

This text would be a worthwhile addition to a nursing library, particularly as an introduction to psychiatry. More detail would seem desirable for those who wish advanced study.

Smoking and Cancer, a Doctor's Report, by Alton Ochsner, M.D. 86 pages. The Copp Clark Co. Ltd., Toronto. 1954. Price $2.25.

Reviewed by Margaret Nesbitt, Cancer Clinic, Victoria General Hospital, Halifax, N.S.

Dr. Ochsner is well qualified for the task of pointing out the hazards of smoking, which he has undertaken in this book. By the use of ample references to authoritative research studies and his own findings, he leaves little doubt of these dangers.

Smokers in particular should read this simple, straightforward account of what happens in their systems in relation to their nicotine intake. The statement that "heavy cigarette smoking more than doubles the death rate from cancer and nearly doubles the death rate from coronary disease" should not be taken lightly.

Dr. Ochsner digresses from the problem of "Smoking and Cancer" enough to show

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other serious conditions that threaten the smoker in much greater proportion than the non-smokers. He also criticizes the tobacco companies for their advertising methods and their lack of responsibility for the health of their customers.

The author, realizing that the use of tobacco will continue with the years, has given a suggested program for breaking the habit. For those who will not give it up completely he outlines the methods by which the health risks may be minimized.

Physiology and Anatomy by Esther M. Greisheimer, Ph.D., M.D. 808 pages. J. B. Lippincott Company, 2083 Guy Street, Montreal. 7th. ed. 1955. Price $5.00.

Previous editions of this text are well-known to instructors and students of nursing. The present edition has undergone re-evaluation of content and certain changes in manner of presentation. The author's objective was to increase the value of the text as an aid in teaching and learning.

The book is divided into five main units. The various systems of the body are allocated and discussed under the appropriate headings. Each chapter contains a very concise summary of its contents. Study questions of the multiple choice variety are included at the end of each chapter as well. These are interesting and valuable but in some instances seem too advanced for the preclinical student. A new section — "Practical Considerations" — has been introduced. This developed as the result of questions asked by students. It constitutes a brief discussion of some of the common pathologic conditions associated with specific body systems. For examples, arteriosclerosis, aneurysm, and varicose veins are dealt with under the anatomy and physiology of the circulatory system. There are a large number of illustrations — a considerable proportion of them in color. They are clearly labelled and understandable. A glossary has been prepared to aid in familiarizing the reader with anatomical and medical terminology.

One section deserves special mention. Most students find the study of the nervous system difficult. This may be the result of the tendency to separate the system into its component parts instead of regarding it as an integrated unit. The author has approached the subject with the emphasis on integration. The use of a familiar situation — an aching tooth — as an analogy in the introductory remarks attracts one's attention immediately. The section is well illustrated with tables and diagrams. The discussion is detailed but pertinent. There has been greater emphasis placed upon relating the rôle of the nervous system to familiar bodily activities.

This is a very readable and useful book. The instructor in anatomy and physiology should find it a valuable aid. Some may consider that there is too much detail. The author anticipated this but included additional information for the student who might be lacking in a supporting basis of scientific knowledge. Considerable thought has been given to the sequence of subject matter based on the needs of the student nurse. For the less experienced instructor, the use of the text *Teaching Physiology and Anatomy in Nursing* by H. H. Flitter and H. R. Rowe in conjunction with this book would be very helpful.

Teaching Physiology and Anatomy in Nursing by Hessel H. Flitter, R.N., B.S., M.A., and Harold R. Rowe, R.N., B.S., M.S. 56 pages. J. B. Lippincott Company, 2083 Guy Street, Montreal. 1955. Price $2.00.

The new instructor often has difficulty in deciding upon the best method to use in presenting her subject. In the words of the authors "this book is intended to offer help to the beginning instructor in physiology and anatomy." To make the text more meaningful, it was developed with specific reference to *Physiology and Anatomy*, 7th edition, by Esther M. Greisheimer.

In introduction there is a general discussion and definition of the usual approaches to teaching. Such terms as "correlation," "integration," and "content-centered approach" are clarified. Succeeding units are related to corresponding units of Dr. Greisheimer's book. No attempt is made to organize subject material for teaching purposes. Suggestions and ideas are offered for the use of the instructor in choosing the best method of presentation. The importance of teaching this subject in integration with the rest of the curriculum is emphasized. Using the student's past experiences as a basis for imparting new information is also stressed.

A plan of time distribution of content is given. This is of limited value. The number of hours allotted to each subject varies from one school to another depending on the organization of the curriculum. A course

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outline is included in conclusion. Senior instructors may have mixed feelings in regard to this. The new instructor will undoubtedly be grateful for it.

It would appear that the authors have accomplished their purpose. While designed primarily for the less experienced instructor, the senior instructor may conceivably find a fresh approach to a familiar subject. This text should prove very useful.

Supervision of Nursing Service Personnel, by Cecilia M. Perrodin, R.N., M.S.N. Ed. 622 pages. The Macmillan Company of Canada, 70 Bond Street, Toronto 2, Ont. 1954. Price $6.00.

Reviewed by Miss Jeanie S. Clark, Director of Nursing, University Hospital, Edmonton, Alta.

The author of this textbook was formerly assistant professor, Nursing Education, De Paul University, Chicago, Illinois. In the preface, she states her three purposes in writing this book as follows:

1. In an effort to demonstrate the role of the nursing supervisor as a harmonizer and a key figure in the achievement of a desirable balance between the legitimate aspirations of those directly or indirectly affected by supervision: patients, community, nursing personnel and hospital and nursing administration.

2. From a belief "that this is the age of supervision, that supervision is the answer to many of the problems of nursing service in all hospitals, large and small, and that a guide to supervision will be welcomed by administrator, supervisors, and teachers."

3. To satisfy students, who, when pursuing courses in nursing education frequently and legitimately complain that they receive the same content in nursing administration courses that they receive in nursing supervision.

It would appear that Miss Perrodin writes on the subject of supervision of personnel assuredly. She has had extensive experience and contacts in the nursing service field and also contacts in the fields of industry and business. She handled her subject under eight units:

Unit One: The Nature and Meaning of Supervision.
Unit Two: Basic Concepts of Importance in Supervision.
Unit Three: Principles of Supervision and their Relation to Supervisory Practices.
Unit Four: Analysis and Organization of Supervisory Activities, Requirements and Qualifications.
Unit Five: Tools of Supervision.
Unit Six: Contributions of Education, Business and Industry to Supervision.
Unit Seven: The Supervisory Program.
Unit Eight: The Fruits of Supervision.

At the end of each unit there appears an extensive bibliography for the use of readers who wish to pursue further references on the subject.

The material is well organized and set out frequently in a tabular or illustrative way. There is a discriminating use of a large and small type which aids in rapid comprehension. For the student and for the nursing service supervisor, this textbook should fill a very real need. I feel that the author has successfully achieved her three purposes.

The following list sums up all . . . of the qualities that anyone working in accident prevention must have: the curiosity of a cat; tenacity of a bull; determination of a taxi driver; diplomacy of a wayward husband; patience of a self-sacrificing wife; enthusiasm of a jitterburg; good humor of an idiot; simplicity of a jackass; assurance of a college boy; tireless energy of a bill collector.

— *Safety Service Newsletter*

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— NEWS OF RED CROSS

* * *

The maiden who takes her time about marrying is usually happier than the one who enters matrimony early in life. This is a conclusion drawn by sociologists from a study of 604 young women, single and married. Psychological tests indicate that the single girls "had better emotional adjustment, greater self-reliance and a greater sense of personal freedom." The tests also showed that those who are in no hurry to marry are less likely to be anti-social. Although most authorities on marriage agree that a woman should not marry until she is emotionally mature, one sociologist points out that their advice is not always followed because it is the immature and emotionally insecure young woman for whom marriage has the strongest appeal. — (ISPS)

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The 1956 Spring Examinations for Provincial Registration will cover two groups of candidates, and will be held as follows:

Examinations for Registration — Part II:

Graduates desiring to qualify for a license to practise will write on *April 9th, 10th and 11th, 1956.* Candidates will not be permitted to write these examinations until they have actually completed their training and hold the diploma of their school.

Applications must be received by February 29th, 1956.

Examinations for Registration — Part I:

Students who will have completed their first year will enter the Examinations for Registration, Part 1, which will be held on *March 19th, 20th, 21st, and 22nd, 1956.*

(Time to be announced in each school.)

Applications must be received by February 8th, 1956.

For application forms and all information relating to the examinations, apply to the headquarters of the Association.

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— Sir Farquhar Buzzard

News Notes

ALBERTA

District 1

Peace River

The officers for the coming year were elected at the last meeting of the season: J. Wickett, president; Mrs. Wanda Campbell, vice-pres.; Mrs. E. Holmes, sec. treas.; committee conveners: Advertising, Mrs. MaMrguerite Greenfield; welfare, Mrs. Nancy Sproul; entertainment, Mrs. Alice Flinn.

District 2

Camrose

The annual Nightingale Dance was held in November under the auspices of the chapter. It was suggested at one of the regular monthly meetings that the members might assist in furnishing the new Community Rest Room as a worthwhile project. At a later meeting it was decided to purchase a play-pen and a bottle warmer to be donated in the name of the chapter to the new community centre.

Wetaskiwin

Mrs. Bresden was appointed as a corresponding member of the Institutional Nursing Committee. The delegates to the annual convention, 1955, have been appointed as a committee to study and submit any necessary recommendations in regard to plans for the 1956 meeting.

At the November meeting of the chapter, Mrs. Asp and Mrs. Climic were appointed to select a slate of officers for 1956. It was decided to donate a sum of money to the Bethany Home to help in the work with orphans and children from broken homes. The guest speaker, Rachael Tasker, gave a very interesting talk on "Home Delivery." The January meeting featured a special program under the direction of Mrs. McWhinnie. High school girls interested in nursing, were guests of honor on this oc-

casion. It is hoped the opportunity to associate with active nurses and to discuss student nurse life will encourage future candidates.

Other guest speakers during the season have been Elsie Henschell, Sydney, Australia and Mr. Schumacher both of whom showed slides of their visits to many parts of the world.

District 3

Calgary

The members of this chapter have had a very busy term. I. Stewart attended a session of the local branch of the Canadian Mental Health Association. Her report proved extremely interesting. The major projects for the past year of the Council of Social Agencies were outlined for the members by Miss D. Guild at one of the meetings. Miss Algard attended a session held by the Women's Bureau, Department of Labor, at which Miss M. Royce, director of the bureau, was guest speaker. Her report clarified the functions of this department. Earlier this past year Sister Leclerc attended a convention for Catholic hospitals and schools of nursing in St. Louis. Members were interested in the highlights which she later presented to them.

A motion to hold a minimum of four chapter meetings a year has been approved. This will require amendment of the district by-laws. At a supper meeting late in the fall, the following officers were elected for the coming term: A. Fallis, president; Mrs. M. Duthie, vice-pres.; J. Cummings, secretary; Mrs. N. Milan, treasurer. In her greeting Miss Fallis expressed the hope that each one would take an active part in the association and thus assure the success of its work.

Interested members were invited to attend a meeting of the Institutional Nursing Committee and to spend an evening at the Calgary Associate Clinic. The need to study the proposed revision of by-laws was emphasized.

The best wishes of the chapter were extended to F. Ferguson for success and happiness in her new endeavor in Ceylon.

High River

Chapter meetings have been well attended, and programs have been interesting. Dr. Little, a recent speaker based his lecture on the subject of "Rest" and the ill effects of confinement to bed. Dr. M. Rowland spoke on the prevention of communicable diseases through immunization, and used a film "The Body Fights Bacteria" to emphasize his remarks at the November meeting. A membership committee has been formed under the direction of Mrs. Robertson and J. Hagg.

Mmes. MacDonald, Betton, McRae and Lyon took charge of the January program. The slate of officers elected for the year was: Mrs. Irving, president; Mrs. White, vice-president; Mrs. J. Dougherty, secretary and R. Sarson, treasurer.

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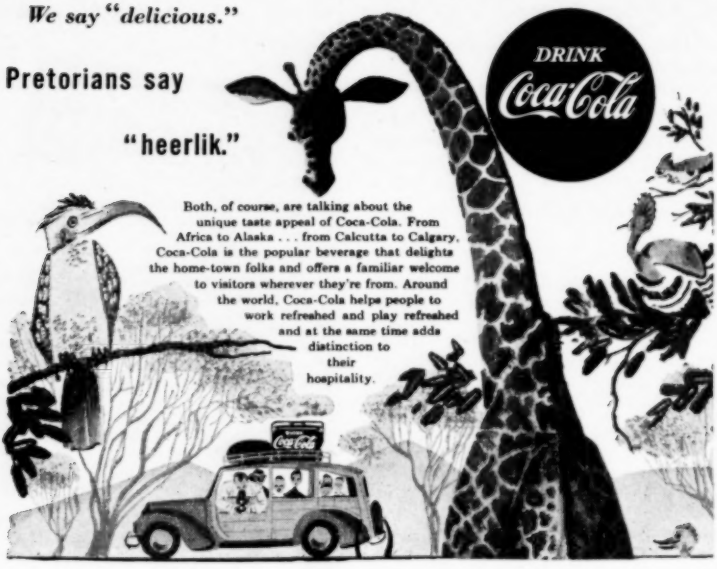
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OLDS

Several members assisted in "Operation Lifesaver" by setting up a first aid station for that day. Mrs. Kinder has been chosen corresponding member to the Institutional Nursing Committee.

VULCAN

Provision of a T.V. set for a shut-in and development of a plan of assistance for a rheumatic heart sufferer have been among the projects undertaken by members of this chapter. Home nursing lectures have been tentatively planned for the future. Mrs. S. Christianson was appointed secretary for the Civil Defence home nursing course.

DISTRICT 4

MEDICINE HAT

Fall and winter activities were resumed at a meeting of the members early in September. The private ward at the Maternity Hospital, which was furnished by the district, is to be provided with new curtains. Mrs. Anderson and Mrs. Montgomerie placed a wreath at the Cenotaph.

Proposed revisions of the by-laws have been studied by a committee under the direction of Miss Bietsch and a report forwarded by this chapter of the A.A.R.N. The Community Nursing Registry report showed considerable activity for November. It was decided that the constitution and by-laws of the registry should be printed in booklet form. Mrs. Renner gave a comprehensive report of the work of the institutional nursing committee at a recent chapter meeting. A brief resume of the civil defence course which she attended in Arnprior was given by Mrs. McKay. The annual meeting was held in January at which the slate of officers for 1956 was presented.

PROVOST

The possibility of sponsoring a blood donor clinic as a chapter project is to be explored. It was recommended that a representative of the local Red Cross branch be invited as guest speaker for a future program.

The development and care of children's teeth was the subject of a discussion by Dr. H. Canniff at a recent meeting. The members found the information educational as well as very interesting.

DISTRICT 5

HANNA

New officers elected for the term are: Mrs. I. Pelltier, president; Mrs. E. White, vice-pres., and M. MacKinnon, secretary. Mrs. B. Stephens and M. Fredgin are in charge of program planning.

Civil defence was discussed by Dr. Argue at one of the earlier chapter meetings.

District 6

Lacombe

Twenty-two members were present at the first meeting initiating the fall and winter program. The chapter plans to assume responsibility for the drive for funds for the Cancer Society — a project successfully undertaken in 1955. A buffet supper in connection with the nurses' formal dance was served as a means of raising funds for the treasury. Dr. McKibbon provided the members with the latest information on the toxemias of pregnancy following the business session.

A detailed and interesting lecture on nephritis by Dr. McFetridge was thoroughly enjoyed by the audience at a later meeting. It was planned to invite a representative of the Cancer Society as a guest speaker at a future meeting.

Red Deer

The past year has been both active and interesting. A bylaw committee was formed to study revisions and then submit them to the executive and members of the provincial association for approval. Funds were provided to help pay treatment expenses for a worthy patient and a donation was made to the polio drive. It was also decided that a contribution should be made to a charity fund. Miss Yuill and Mrs. McKeoun attended the annual provincial convention earlier this year.

Increasing the active membership has received serious consideration. Members have been asked to cooperate individually in trying to increase attendance. Dr. More, Mrs. C. Van Dusen and Mr. Taylor, psychologist, have been guest speakers at various times during the past year. Miss Ross from the V.O.N. headquarters, Ottawa, was present at one meeting and outlined the steps necessary to set up such a service in the district.

The establishment of a nursing scholarship has been undertaken as a major project by this chapter. A committee has been formed to draw up the list of requirements necessary. It has been decided to use a portion of the funds to assist a student to complete her basic nursing education. Mrs. Davis was nominated to represent the institutional nursing group. Members enjoyed a social evening at their December meeting.

District 7

Jasper

Miss Gilda Graves, whose work among the Indians with her study of rare blood types has provided so much interest, gave a very informative address at a recent meeting. Dr. Venner discussed "Misunderstood Illnesses of Childhood" and "Epilepsy" as guest speaker during the past year. It was decided to seek advice in the selection of films which would be of interest to the members.

The topic of breast cancer was discussed

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by Dr. Betkowski and a film shown at a late fall gathering. Plans were completed for the monthly Baby Clinic and three members were selected to assist with this. The Christmas banquet was held in the C.N.R. dining room and was followed by a party at the home of Mrs. Graves. Dr. O. Hogan, Dr. and Mrs. Betkowski and Dr. Vinner were honored guests for the evening.

Edmonton

Discussion of proposed by-law changes was of major concern at a recent chapter meeting. A suggestion that an enlarged executive of the district meet and study such changes was accepted. R. McLure gave a most interesting talk about her course in public health which she had taken in Pittsburgh. Many highlights about the city itself were included. Miss McLure acted as chairman of the nominating committee for the January meeting.

Stony Plain

The programs for future meetings have been the chief topics of discussion at chapter sessions this past fall. Members have been submitting suggestions in regard to this. Welfare organizations are to be approached with the hope of obtaining speakers. A recent guest speaker was Dr. Gillespie, medical health officer for Lac St. Anne Health Unit. His topic, "Maternal Deprivation and Mental Health in Children" was most interesting. Two films, "Crossroads" and "Miracle Fluid" were presented at one of the past meetings and proved both educational and enjoyable.

Vermilion

The following slate of officers was elected for the current season: Mrs. K. Brix, president; Mrs. Alice Soldan, vice-pres.; Mrs. V. Barr, secretary; J. McPhee, treas.

The chapter is directing a scrapbook competition on Cancer Education among school pupils in the local area. This contest is being sponsored by the Alberta division of the Canadian Cancer Society. A home cooking sale was held late in the fall as a money making project.

District 8

Pincher Creek

Members of the chapter assisted with the Blood Donor clinic held recently. A course in home nursing has been planned with two volunteers from the chapter contributing their services.

Taber

An organizational meeting was held in the Municipal Hospital to form a chapter of the A.A.R.N. The officers elected were: Mrs. Nicol, chairman; Miss Gamble, vice-chairman; Miss I. Okamoto, secretary; Mrs. Rash, treasurer. Bylaws were adjusted and accepted. Meetings are to be held monthly. Members have decided to help with the Baby Clinic as one project and to sponsor the annual nurses' dance.

BRITISH COLUMBIA

Ladysmith

The annual meeting of the chapter was held in November with 15 members present. Mrs. J. Berto presented the report of a successful year with varied activities.

Officers for 1956 were elected as follows: President, Mrs. H. Steele; vice-pres., Mrs. P. Gannon; secretary, Mrs. J. Ulaga; treasurer, Mrs. J. Mitchell; social convener, Mrs. A. Quayle. Miss O. Jami, Miss H. Fulmore and Mrs. D. B. Quayle attended the institute in Nanaimo on "Body Mechanics and Rehabilitation Nursing." Miss C. Charters conducted this valuable course which was sponsored by the R.N.A.B.C. The purpose of the course was to provide instructors for the local chapters.

Vancouver

St. Paul's Hospital

The members of this year's graduating class were entertained at a buffet supper by the alumnae association. Mrs. Collishaw presented a trophy to the outstanding student in each section on behalf of all alumnae members. Outside graduates presently on staff were guests of honor at the annual Christmas party. A bazaar was held early in December and featured home cooking and sewing.

News of the graduates reveals that A. Klassen, N. Martens and A. Friesen are working in Kelowna. A. (Mellor) Pulfer is on the staff of the Royal Inland Hospital, Kamloops while B. J. Mellor is at the King Edward VII Memorial Hospital, Bermuda. R. Wolfe is working at the Western Hospital, Toronto and Miss Galloway at Welland County Hospital, Ontario. P. Johncox completed her postgraduate studies in surgery at the General Hospital, Vancouver and is in Fresno, Calif. E. Ropas and P. Branca have started postgraduate study in surgery in their home school. G. (Larson) Alder has joined the staff of the Central Supply Dept.

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NEW BRUNSWICK

MONCTON

General Hospital

Nurses' Hospital Aid

Authority to purchase a motion picture screen for the nurses' classroom was given to K. Richardson and Mrs. C. Colwell. This was an outstanding feature of the November meeting of the members. A recent cooking sale with a drawing for a cake added substantially to treasury funds. Small gifts were collected for distribution to sick members at Christmas. Mrs. C. Forsythe was welcomed as a new member. The student nurses were presented with 25 season skating tickets as a Christmas gift and the members enjoyed a special Christmas program and exchange of gifts at their December meeting.

ONTARIO

DISTRICT 5

TORONTO

St. Michael's Hospital

A meeting of the alumnae association was held prior to the Christmas season. Plans were made for the preparation and mailing of gift boxes to sick nurses, and for a theatre night. The annual nurses' dinner was held early in December in the residence.

G. Ferguson has been appointed to the teaching staff of the obstetrical department. M. Hough has joined the staff of Baker Clinic, Edmonton. M. Willsher is stationed in Zweibruchen, Germany with the R.C.A.F., while M. MacKenzie is working in St. Joseph's Hospital, Ann Arbor. S. Walker is presently in New York at the Neurological Institute, Presbyterian Hospital. B. Burns is taking postgraduate study at Boston University. R. Krmpotic has joined the staff of Franklin Hospital, San Francisco. B. Kelly and M. Noble are on the staff of the Montreal General Hospital. The appointment of F. Roach as Dean of Nursing Education, Assumption College, was noted with pride.

Women's College Hospital

In recognition of her years of service and as a token of their regard for her, members of the alumnae association presented Miss C. Dixon with a piece of luggage. The presentation was made by Mrs. Mary Roberts. Mrs. M. Hood, who also has given many years of faithful service to her hospital and alumnae, received a life membership in the association and a bouquet of red roses. These were highlights of the last meeting of the association for 1955 at which Dr. Ferreira was the guest speaker.

The class of 1931 is making tentative plans for a reunion, marking their 25th anniversary, following the graduation dinner this coming spring. It is hoped that other

classes will follow their example. H. Muir has joined the staff of the new Sudbury Memorial Hospital. R. Duff visited the hospital recently and was the guest of honor at a buffet supper and a tea. M. Kerr recently returned from Europe.

District 12

Kapuskasing

A new chapter has been formed which includes Cochrane, Kapuskasing and Hearst areas. In spite of the distances which must be covered to permit attendance, interest is high and the members plan to hold monthly meetings — eight in Kapuskasing and two in Cochrane. The first meeting was held in November at the Sensenbrenner Hospital under the chairmanship of Mrs. Loosemore, district president. The slate of officers elected was: G. Larocque, president; J. Warrington, 1st vice-pres.; Miss Millredge, 2nd vice-pres.; P. Osborn, membership convener.

SASKATCHEWAN

Saskatoon

City Hospital

The annual tea and bazaar of the student nurses' association was held under the auspices of the class of 1957A. Mrs. H. Armstrong, Misses J. Bernie, M. Gibson and E. Klewchuk received the guests. Mrs. D. Wilkie, Misses L. Willis, M. MacKenzie and E. Pearston presided over the tea table. D. Kacsmar and I. Levorson, scholarship students of last year, are attending the University of Saskatchewan. E. Redden and A. Hompoth have joined the staff of the nursing school office as assistant night supervisors.

Regina

Members attending a recent chapter meeting experienced a rare treat in hearing Dr. H. B. de Groot discuss folk music. In the short time at his disposal, Dr. de Groot outlined the evolution of folk music and illustrated with records. Music of the British West Indies, Russia, Spain and Hungary was played. The gypsy music of the latter two countries was especially enjoyable. A short business meeting followed.

General Hospital

The school of nursing is the proud owner of a new movie projector, with plans to acquire a new slide projector in the near future as well. The gymnasium in the recently completed nurses' residence is much appreciated by both graduate and student nurses as indicated by the increasing activity. Mrs. A. Stewart and Miss M. Lyons attended the institute on "The Role of the Nurse in Civil Disaster" held at Fort Qu'Appelle.

Grey Nuns' Hospital

The student nurses are planning a special ceremony to welcome a new and modern "Mrs. Chase" into their school. Mrs. H. McCormack and Miss V. Ryan attended the Civil Defence institute held in Fort Qu'Appelle. C. Kenny attended and enjoyed the course held earlier this year at Civil Defence College, Arnprior. D. Percy, Chief Nursing Consultant, Department of National Health and Welfare, visited the school of nursing recently. Mrs. Ellis has resigned from the staff.

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Registered General Duty Nurses for medical & surgical. Rotating shifts, Good personnel policies. Apply Director of Nursing, The Greater Niagara General Hospital, Niagara Falls, Ontario.

Registered Nurses (3) immediately for 36-bed General Hospital in southern Manitoba. Starting salary: $205 per mo. with 3 wk. vacation with pay 1st. yr. employment; 4-wk. vacation thereafter. All statutory holidays. Regular sick leave, 50% Blue Cross payments. Apply Supt. of Nurses, Hospital Dist. No. 24, Box 330, Altona, Manitoba.

Registered Nurses for surgery, must be able to scrub & circulate. Starting salary: $325 per mo. plus other benefits. **Registered Nurses** for general floor duty start at $300 per mo. plus other benefits. Must be able to get New Mexico registration. 30-bed hospital to move into new 70-bed hospital soon. Apply Supt. of Nurses, Memorial Hospital, Carlsbad, New Mexico.

Registered or Graduate Nurses for General Duty (2) for modern 20-bed hospital. Salary & increments in accordance with S.R.N.A. recommendations. 1 mo. vacation & sick time with pay after 1 yr. service. Separate staff residence. Apply Sec.-Man. Riverside Memorial Hospital, Turtleford, Sask.

Registered Nurses for General Duty Staff. Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Graduate Nurses for 100-bed West Coast General Hospital. Salary: $250 per mo. less $40 for board, residence, laundry. 3 annual increments; $10 per mo. night duty bonus. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance up to $60 refunded after 1 yr. Apply Director of Nursing General Hospital, Prince Rupert, B.C.

Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

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Graduate Nurses for duty on Obstetrical, Medical & Surgical Wards. Personnel policies as recommended by the Assoc. of Nurses of the Prov. of Quebec. Please apply Director of Nursing, Queen Elizabeth Hospital of Montreal, 2100 Marlowe Ave., Montreal 28, Que.

Graduate Nurses & Dietician (1) for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: $200 per mo. Annual increase $10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

General Duty Nurses for small hospital. Salary: $200 per mo. plus maintenance. 8-hr. day, 44-hr. wk., statutory holidays as outlined by R.N.A.O. Travelling expenses refunded after 12 mo. service. New nurses' residence under construction. Apply Lady Minto Hospital, Chapleau, Ontario.

General Duty Graduate Nurses for well equipped 72-bed hospital on B.C. coast. Salary: $222 per mo. less $25 full maintenance. Semi-annual increments. 28 days vacation plus 10 statutory holidays after 1 yr. Apply Matron, St. George's Hospital, Alert Bay, B.C.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses for all departments. Gross salary: $210 per mo. if registered in Ontario $200 per mo. until registration has been established. $20 per mo. bonus for evening or night duty; annual increment of $10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing. General Hospital, Oshawa, Ont.

General Duty Nurse for well equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn. Boating, fishing, swimming, golfing, curling, skiing. Initial salary: $240, full maintenance, $40. 44-hr. wk. vacation with pay. Comfortable, attractive nurses' residence on grounds. Rail fare advanced if necessary, refunded following 1 yr. service. References required. Apply Bulkley Valley Dist. Hospital, Smithers, B.C.

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General Duty Nurses for 650-bed teaching hospital in central California. Salary: $288-$337 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

General Duty Nurses. Salary: $230-270, $10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, (1) mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Staff Nurses for 600-bed General & Tuberculosis Hospitals with School of Nursing. Salary: $288-$341. Shift, special service & educational differentials, $10. 40-hr. wk; 3-wk. vacation; 11 holidays; accumulative sick leave. Apply Associate Director of Nursing Service, County General Hospital, Fresno, California.

Staff Nurses & Operating Room Scrub Nurses for 225-bed General Hospital, 20 mi. north of New York City. Salary: $240-$280. $20 extra for O.R. duty & permanent evening duty; $15 for permanent night duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

Operating Room Nurses, immediate appointments, for 511-bed newly enlarged and finely equipped hospital; 10 operating rooms now completed. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial and educational friendly activities; living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburg, Pa. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary: $240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

Operating Room Nurses, preferably with experience, for 75-bed hospital. Operating unit consists of 2 theatres, emergency treatment & recovery room. Apply Supt., Carleton Memorial Hospital, Woodstock, N.B.

Operating Room Nurses (Immediately). Rotating shifts, good personnel policies. Apply Director of Nursing, The Greater Niagara General Hospital, Niagara Falls, Ontario.

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Operating Room Nurses (2) for 60-bed General Hospital. Apply Superintendent, Leamington District Memorial Hospital, Leamington, Ontario.

Maternity Nurses for modern 60-bed General Hospital located 40 mi. south of Montreal. Salary: $155 per mo. 8-hr. duty; 44-hr. wk; rotating shifts. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

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Dietitian (qualified) for Teaching Hospital. Opportunity for advancement. Full maintenance. Fare from Canada for accepted candidate. For full particulars, write, giving qualifications & date available, Matron, King Edward VII Memorial Hospital, Bermuda.

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Operating Room Supervisor for Ontario active surgical unit of 100-bed hospital. Approx. 1,800 cases annually. Vacation after 1 yr. of service. Sick leave, statutory holidays & Blue Cross Plan. Postgraduate diploma desirous but not necessary if experience is adequate. Apply The Director of Nursing, Cottage Hospital, Pembroke, Ont.

Graduate Registered Nurses for general duty for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary $300. Good personal policies. Apply Highland Park Hosp., Foundation, 718 Glenview Ave., Highland Park, Ill.

Registered Nurses for 82-bed accredited hospital. Gross Salary: $210-$230 per mo. 44-hr. 5½-day wk. with no split shifts. 30 days vacation with pay after 1 yr. of service plus statutory holidays. Room in a comfortable residence & laundry of uniforms provided at $10-$12 per mo. Apply Supt. of Nurses, Union Hosp., Canora, Sask.

General Duty Nurses for 40-bed hospital. Salary $250, full maintenance $45. 42-hr. wk., 28 days annual vacation plus 10 statutory holidays. Rotating shifts, cumulative sick leave, self-contained residence. Apply Director of Nursing, General Hospital, Princeton, B.C.

General Duty Nurses for Pediatrics, Medical, Nursery & O.R. **Scrub Nurse** for new 165-bed hospital plus 35-basinettes. Excellent salary & generous personnel policies. Apply Director of Nursing, General Hospital, Pembroke, Ont.

General Duty Nurses for 114-bed hospital. Salary: $220-$250 with $5.00 increments every 6 mo. 44-hr. wk., 3-wk. annual vacation, statutory holidays etc. For further particulars please apply to Director of Nurses, Union Hosp., Swift Current, Sask.

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